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Communications.

TWO INTERESTING CASES OF JUVENILE CONVULSIONS.

Read before the Macon County (Mo.) Medical Society,

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Of Woodville, Mo.

On February 14th, 1880, I was called, in a hurry, to see a boy aged 5 years, said to be dying. This boy's history, in brief, is as follows: Was born apparently a healthy child, from healthy parents. When two weeks old, he lay for three weeks in a partially comatose condition, with spasmodic jerks and twitching on one half of his body; he finally got better, but all his life he has been subject to convulsions at times, coming on apparently without cause, and always accompanying any fever he might have. For the last few months he has been in fair health, but has an enlargement of the spleen which seemed to cause him no trouble, and was not treated; the child, although apparently bright, had never talked and had been more or less troubled with worms, which were easily expelled with calomel and santonine. The present attack commenced some time in the night previous to my being called in, the mother being awakened by the child apparently choking and struggling for breath, being black in the face, to use her words, and suffering from a general convulsion, with spasm of the glottis, which made the mother think (who by the way is not overly bright) that the child had a sore throat, to which she directed her domestic remedies, honey and vinegar, pepper tea, etc. The child would have a fit, she said, every five minutes, and would be cold as ice one minute and as hot as fire the next, had a very sick stomach and vomited frequently. This state of affairs continued till between 1 and 2 P.M., when the child's right side (arm, leg, eye and corner of the mouth) was attacked with a jerking, not very fast, but continuous.

I arrived soon after this time, and found the child lying in a cradle, surrounded by several distracted old ladies and the grief stricken mother. The child was lying still and breathing naturally, face rather pale, eyeballs both turned as far in one direction as the recti muscles would allow; pulse was discernible but not countable, from weakness, and quickness; while examining the child, but two or three minutes, there commenced a general spasm of the right side of the body and face; pupils largely dilated. I had the child's head pulled from over the cradle, put my handkerchief over its face, and poured half a gallon of ice water on its head from a slight elevation, but saw no improvement. The patient could not swallow. I had no chloroform or rectal syringe. I then ordered a tub of hot water, put in some mustard, and set patient therein, bathing his body and lower extremities, at the same time keeping ice to his head. The jerking of his right leg kept the water in a perfect commotion; saliva would gather in his throat and mouth, so that we would have to hold his head, that it might run out. After keeping the child in the bath for about five minutes, took him out, wiped him dry, rolled him up in a blanket, but still the spasm kept up. It had then been on perhaps half an hour. I was about at my wit's end; I

could scarcely detect any radial pulse, and then only by bracing cradle against leg with one hand as I searched for pulsation with the other, as the spasm shook every part of the patient; but still there was but one side in convulsion, and that seemed to be internal as well as external, affecting the voluntary as well as the involuntary muscles. The parents had got the child to swallow a good dose of castor oil and turpentine, which acted now copiously; but there was no change. At this stage I took the temperature, for the first time, in both axillæ, and I found it 103 on both sides. I thought now I had the key to the thing; reduce that temperature and you will cure that spasm. So I took a sheet, wrung it out of tepid water, and wrapped up my now naked and still jerking patient. I was still applying cold to his head, and several times would cover his face with a handkerchief and pour on from a quart to half a gallon of ice water. I now cut off his hair and had his scalp continuously rubbed with ice. After patient had been in the wet sheet, which I had frequently sprinkled with cool water, for about ten minutes, I had him taken out, wiped dry, and wrapped up in a blanket. In a few minutes I again took his temperature, which I found reduced two and a half degrees, or to 100½. I had several times tried to give patient a solution of bromide of potassium, but did not know that he swallowed one drop. Still no abatement of the spasm. I then sent a messenger for a syringe and some hydrate of chloral (forgot to send for chloroform). While messenger was gone, and after a continual spasm of one and a half hours, it gradually nearly ceased, but only for about three minutes, then patient could move his eyes, and apparently noticed when called. But in about three minutes I noticed his eyeballs drawn to one side, his mouth begin to draw, his arm and leg to jerk as hard as ever (having never stopped entirely). In this short lull I still kept ice to his head, feet wrapped up in hot cloths, as they were getting cold; pulse at wrist at times not discernible. In a short time patient began to sweat on forehead, a rather cool, clammy sweat; extremities and end of nose cool; it looked as if death was imminent.

When the syringe arrived I took two ounces warm water, 25 grs. bromide potassium, and ten grs. of hydrate of chloral, and injected up the rectum, where it was retained. In about twenty minutes or less patient's jerking partially ceased, that is, all but the fingers and toes; his eyes would roll from side to side and apparently follow a person, but still he made no signs that he could hear when spoken to. I had told the attendants that patient would probably be paralyzed on that side of the body, which proved to be the case. Pinching him or tickling the bottom of his foot was not noticed on the affected side, while on the other side he was extremely sensitive. Pupils would not contract when a strong light was brought in close proximity to them, but kept largely dilated. Pulse was now tolerably strong and about 130, temperature 99½°; patient could not yet swallow, and his mouth had to be wiped free from saliva, to keep him from choking. As I could not stay any longer with the case, I ordered perfect quiet until he could swallow, when he was to receive, every two hours, four powders of calomel, santonine and quinia, with a teaspoonful of a solution of bromide of potassium between each dose. Should he not be able to swallow, and spasm return, to repeat injections of potassium and chloral, ice wrapped in a cloth and constantly applied to head. Left the case at 6.30 P.M.

Feb. 15, 8 A.M., messenger informed me child was still alive, had had no more spasms, was able to swallow, and had slept pretty well during night. As bowels had not moved I ordered a good dose of oil and turpentine. 9 A.M., saw the child, who was asleep; temperature 99°, pulse 130 and weak; pupils, while asleep, contracted, while awake well dilated; could move hand or foot on right side but little; seemed to be easily aroused and to know what was said to him; would take an object with his left hand, and try with his right, but he could not close his fingers. At 10 A.M., two hours after giving oil, gave an enema, which passed at once, with some little fecal matter and one large, round worm. I then left two more powders of calomel, santonine and quinine, to be given every two hours, followed in six hours with oil and turpentine. After taking calomel and santonine, I gave quinine every two hours, with a teaspoonful of a solution of bromide of potassium as needed. Head to be kept cool.

Feb. 16, A.M. Patient apparently doing well; no more spasms, but some trouble in deglutition. Temperature 98½, pulse 120; bowels moved this morning, when he passed several worms. He rested poorly during the night; he can walk a little by being held up; while laying in cradle is continually throwing his left leg over his right. The boy gradually recovered, after taking two more doses of santonine, tonic doses of quinine and bromide, to control restlessness. He was a month before he could use his right arm and leg. Since that time he occasionally has a convulsion, but not so severe or often as

he used to, and is now able to talk a little better. This was the hardest and most protracted case of convulsions I ever saw or read of, and, from its history, it must have been caused first by worms, and secondly by a temperature five degrees above normal.

One other case I have just seen was somewhat similar. June 7th, this year, was called to see a child, six months old, of Mrs. T. R's. It had always been healthy, and was the fattest little baby you ever saw. It lay in its cradle, surrounded by its heartbroken aunts, grandmothers, and all the old ladies for a mile around. I was met at the door by its mother, with the exclamation, in agonized tones, Oh, Doctor, my baby has got the croup and is dying. There was gurgling respiration, from the accumulation of mucus in its throat, and I noticed its left hand and leg jerking. I asked how long it had been jerking that way. They said about two hours. I asked if it had anything like a fit before it commenced jerking on one side only? yes; did it froth at its mouth? yes; was it pretty hot? yes; how was it yesterday? it was all right till evening, when it was funny, and had a little fever; how was it the day before? just about the same, only not so bad. Did you notice it cool any to-day? yes, it was right cold about two hours before this jerking commenced. Pulse was going at the rate of about 200 per minute; could not count it. The child felt rather warm. I put my thermometer in its groin and up it went to 105. This child could yet swallow. I gave it some bromide and about half a drop of tincture aconite. Stripped the child and wrapped it up in a cold, wet cloth, frequently sprinkling it with cool water; took it out in about fifteen minutes, wrapped it up, after drying it, kept cold applications to its head, gave it another dose of bromide, and in about ten minutes spasms ceased; temperature now 103. Put the case on a couple of doses of calomel, followed by quinine, to be given every two hours; the bromide and aconite to be given between each dose, as long as fever was high.

The next morning, June 8th, temperature 100; pulse 120; child drowsy, but could be aroused. Had another one-sided spasm during the night, which was of short duration. The child was perfectly paralyzed on one side, but nursed heartily. Gave two more doses of calomel and continued quinine and bromide, discarding aconite.

Evening, June 9th. Since I had been there the child had several one-sided spasms, and while I was examining it I noticed, first its eyes drawn to the left, then its mouth and cheek, then its left arm and hand, and at last its leg. It would rattle in its throat, and frothy saliva would run from its mouth. This was the kind of spells they said it had been having. This lasted about five minutes. Temperature 99°, pulse 120, regular; respiration 36, regular; face pale; could not use its leg or arm, and would not move its foot by tickling the bottom, but would flinch a little from the prick of a pin. I could not account for these spasms now, from the temperature, but judged there was serous effusion in the right hemisphere of the brain.

I kept child's head cool, bowels open with calomel, and put the case on iodide and bromide of potassium, and an occasional dose of quinine.

In about a week I heard that the child was in apparent good health but still could not use its left side.

June 28th. Child was brought to my office, and upon examination I found its temperature 99, pulse 100; nothing abnormal about the appearance of its head; posterior fontanel closed, anterior considerably opened, but appearing natural; nothing abnormal about its eyes, both pupils being equal, and no strabismus. Child was and had been quite fretful, and at times was said to have some fever; it ate and nursed as hearty as usual. Sensibility on its left side considerably diminished, but would flinch some on the stick of a pin or by tickling the bottom of its foot. But there was nearly a complete loss of mobility in both arm and leg, and it would bear no weight on affected leg; would try to hold an object in its affected hand, but could not flex its fingers. I used the faradic brush with a weak current to its limbs, but could use considerable power before it would appear to notice it. I fancied I could see a little improvement after the use of the battery. I put the case on tonic doses of quinine and strychnine, with bromide and chloral hydrate, as needed, to control restlessness.

Now to what can we attribute the cause of this hemiplegia and former unilateral convulsions? They are but symptoms, what is the disease? It is a lesion of some nerve centre. It may be functional, from some reflex cause, or organic, from clots of blood, effusions, tumors, inflammations, or softening. Any lesion in the continuity of a nerve will produce paralysis; also will any disturbance of the periphery or extremities of nerves; this is generally local in character.

—Prof. Nothnagle has now definitely assumed his duties as Professor of Special Pathology, Therapeutics and the Medical Clinic, at the Vienna University.

PRACTICAL CONCLUSIONS WITH REFERENCE TO ABSCESSES.

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A pursuance of the subject of suppuration would as naturally lead to that of abscesses, as the physical and chemical course of suppuration in the human body brings about their formation. The definition is drawn when a cavity is filled with or made by the formation of pus, in distinction from suppurative infiltration, which is sharply and technically defined by a collection of pus in a natural, already existing cavity—such as a joint, or the thorax. I am speaking only a word, it is true, with regard to abscesses in general. Nevertheless, it is intended to have more especial reference to those that are developed from an acute inflammation, occurring on the spot where they are seated, as well as to those so-called cold abscesses. The sinking or congestion abscesses which appear at a place further from or nearer to the source of suppuration, not unfrequently, in diseases of the bone, claim really only a technical distinction, belonging essentially to hot abscesses. The same may with equal truth be affirmed of the metastatic abscesses that accompany pyæmia. The subject of abscesses, perhaps, at first glance would seem to be of rather secondary consideration, as belonging to minor surgery, as being quite common and generally unfraught with danger. But a moment's thought cannot fail to convince even a superficial observer, that the study of abscesses is one of the most important and most interesting in all the domain of surgery, and the more so, as they belong to the most frequent of surgical diseases. Their diagnosis (by no means always easy) and their treatment, at times very difficult, merit, therefore, the attention of students and practitioners, both young and advanced, general and special. In order to prosecute the study of abscesses successfully, a knowledge of their anatomical conditions and natural processes is necessary. These may be briefly summarized as follows: 1st. *Seat.* Abscesses can form in all tissues; they have even been observed in blood coagula (plugs of blood). They can form at any depth; although I have oftener found them nearer the surface, than in the depth of an organ. 2d. *Form.* Every abscess has an inclination to a spherical form, and for this reason, that, as a general rule, they are equally, at least on several sides, compressed by tissues of the same consistency. Of course, the form varies at times, now being like a long, deep pocket, and again with several shallow cavities connecting or separated. 3d. The number of the abscesses is sometimes very great in one and the same body; in this case, the formation of abscesses generally rests upon an internal cause. In most cases, however, only one abscess is found, or at most, only a few near each other.

4th. *Direction.* Abscesses have, under all conditions, and no matter where situated, the tendency to enlarge toward the surface of the body. This has its explanation in the greater difficulty which the more tense tissues in the depth offer to its further progress in their direction; nevertheless, further progress and breaking through into a serous sack may be possible. There have been examples of this. The son of I. L. Petit died from the breaking through of an abscess into the cavity of the breast; in such a case the saving of life is no longer to be thought of.

5th. *Construction.* Ordinarily the cavity of the abscess is lined with a characteristic pseudo-membrane, which Delpech accepted as constant in all abscesses, and named, accordingly, membrane pyogénique, abscess membrane. This, however, is not found in very freshly formed abscesses and can also be totally wanting in those that have existed longer, as, for instance, in diffuse phlegmon, and it is of itself understood, that it is not a necessary accompaniment of suppuration, being rather the outcome of a collection of pus. It goes through different modifications, according to the quantity and quality of the pus, more especially as to whether the abscess-cavity communicates with the air or not.

Termination of Abscesses.—Pus being regarded as a diseased formation and foreign body, relatively speaking, cannot remain very long in the human body; causing, like other foreign bodies, a more or less pronounced inflammation in its surroundings. This inflammation induces ulcerative processes, resulting in the abscess breaking through the skin and emptying the pus without. The collection of pus in an abscess can also be removed in another way, although much rarer, namely, by absorption. The abscess membrane is made, by some authors, the organ by whose means the absorption of pus can take place, in a manner harmless to the organism. The fact is that an abscess can empty itself without an opening, and then nothing more remains for us but to accept that the pus has again been taken up into the vascular system.

When resorption of pus takes place in an ab-

scess it is noticed that its volume becomes smaller and its contents thicker. Such a change can go on from one day to another, in the most marked manner. First the pus serum is effused. The pus corpuscles then appear to approach their solution by a transformation of their contents into fat. At least, long before the microscope was used to throw light upon pathological process, it was observed by Dupuytren, and others, that, without doubt, abscesses containing pus, after resorption of the pus-serum, can change themselves into cysts containing fat. This fat has been found to resemble fat-wax, which sometimes develops itself in dead bodies—adipocere.

This fat can likewise later on be resorbed itself; finally, the abscess membrane is pushed together by the surrounding parts and reduced to a fibrous layer, which is not unlike an inscriptio tendineæ. An external and visible impression may remain in the place where the abscess was healed by resorption, but this, by good nutrition, will afterwards fill out with fat. There is, therefore, in this resorption, no fear of pyæmia, for it is a question of resorption of pus serum by secondary formation, in which the pus corpuscles undergo a fatty solution, there being no reception of pus pure and simple into the blood through the porous coats of the vessels. When resorption does not follow, the abscess either empties itself within or without by ulcerative process, or is emptied by mechanical procedure without. The contact with the air, as soon as the latter takes place, causes a reddening of the abscess membrane; it swells, the flow of pus becomes richer, and there undergoes a qualitative change. Besides the already mentioned breaking through of abscesses without or into a serous cavity, there is also a third possibility to notice, viz., the breaking through of an abscess into an intestine covered with a mucous membrane. Such a circumstance presupposes the adhesion or growth of the outer surface of the intestine to the walls of the abscess. Although this is certainly, in general, less favorable than an emptying at the external surface of the body, yet there are cases in which it appears desirable; in abscesses of the iliac fossa, an opening into the colon is a fortunate termination; the case is similar with deep abscesses of the parotid, in which a breaking through externally would cause apprehension as regards a fistula remaining behind, while opening into the cavity of the mouth is not followed by any evil consequences.

On the other hand, breaking through of an abscess into the middle portion of the intestinal canal is very dangerous to life, the more so the nearer the stomach, as the presence of pus interferes with the digestion, and the pus has a long distance to go before it can be removed out of the body. When no other unforeseen evil circumstance occurs, and the cause of suppuration is removed, filling up of the abscess cavity begins with the emptying of pus. This filling up takes place by granulation. When this runs its course normally, cicatrization finishes the physico-pathological process.

Diagnosis.—Samuel Cooper said, most justly, "Nothing is more calculated to make known the sharp and experienced coup d'oeil of a practitioner than the facility with which he recognizes deeply-seated collections of pus; nothing, on the contrary, can so easily shake confidence in him as an error made in this respect."

With heat, swelling, pain, redness and *fluctuation*, our diagnosis, in very many cases, is complete. *Fluctuation* is the decisive point. It is the most certain sign of the presence of pus, being determined by a sensible movement of liquid matter in the tumor (swelling), when struck gently or suddenly compressed for a few seconds. The best way to determine fluctuation is to use both hands, placing one opposite the other on the swelling, and then push, with the open fingers kept close together, the sides of the swelling alternately toward each other. In this manner the contents will often be felt to beat against the sides, and thus fix a diagnosis. Very little difficulty is thus experienced, provided always the abscess can be got at. It is, however, at times not easy, and, indeed, fluctuation may be wanting entirely. This can occur from the consistency and thickness of the parts covering the abscess, from too great a consistency of the pus, and finally, from the abscess being overfilled with pus, and thus producing hard, stiff walls. A strong cathartic, by causing a partial resorption of the pus, often leads us to feel the wanting fluctuation. On the same grounds fluctuation may fail in ascites, in hydrops of the joints, and in hydrocele. As regards the consistency of pus, with reference to feeling fluctuation, there are organs in which always only very thick pus forms. For this reason, abscesses of the liver, even when situated near the skin, are difficult to diagnose. Broad superficial abscesses, for instance, such as form from a diffuse inflammation of cellular tissue, have no, or at most very indistinct, fluctuation, on account of being spread out in a thin layer.

In spite of all technical rules, the most experienced surgeon cannot sometimes discover fluctuation, while other signs point to the presence of an already completed formation of pus. Here belongs first œdema, the tough, spongy swelling which especially leads us to suspect the beginning of suppuration in the extremities, and which in inflammations of such parts as are surrounded by fast fibrous skins is never absent as soon as they go into suppuration. Further to be noticed are, the etiological conditions, the duration of the inflammation, the texture of the inflamed tissues, the constitution of the patient. The pain, which during the inflammation was spanning or sticking, becomes commonly throbbing, the patient feels often a beat in the abscess isochronic with the beats of the pulse. If fever has already developed itself there are formications or chills.

Among the tumors with which abscesses can be confounded are, particularly, aneurisms. These are tumors with a cavity containing blood, this cavity communicating with an artery. Among them those aneurisms that develop themselves from inner causes (without a wound preceding) are the ones that give rise to such a mistake. To avoid this the following points must be strictly observed: An aneurism forms at first a soft tumor, that in part or entirely disappears upon pressure.

As a distinguishing mark here, the abscess is of harder consistency and less impressionable, the younger it is; in the first stages of its development it is quite impossible to diminish it in the least by pressure. In the further course the relations change, the abscess becomes soft, the aneurism becomes hard, and this change in the consistency in abscesses is most marked on the summit or point, in aneurisms at the base. Arrived here, we can make a correct diagnosis in most cases, for the rhythmic arterial pulsation of an aneurism is absent; we say in most cases, not overlooking the fact that certain abscesses form with a pulsation so like that of an aneurism as to perplex the most experienced. The pulsations, then, that can be felt in both tumors, merit an especial consideration. An abscess often has its seat in the inter-muscular spaces, filled up with connective tissue, in the depth of which the larger arteries run; the abscess can, therefore, by the pulsations of the artery or arteries, rise and fall isochronic with the beats of the heart. But we have here to do with an impulse given to the tumor, which can only be felt distinctly on that side lying nearest the pulsating vessel, and which, by pushing aside, if this can be done, can be at once arrested. On the other hand, an aneurism shows pulsation in its entire circumference, and in form of a widening of the whole tumor isochronic with the pulse and rhythmic. This can be felt whenever and wherever the finger is placed, and is not changed by pushing aside the tumor. The period of existence has a direct influence upon the pulsation in both kinds of tumor. The older the aneurism the less distinct the pulsations, on account of the formation of layers of fibrin on its walls; the older the abscess, contrariwise, the more distinct the pulsations become when situated upon an artery, because, always increasing in size, it continually nears the artery, and its liquid contents extending, are more easily set in motion by the beats of the artery. The conditions become much more complicated when an abscess and an aneurism exist next to each other, or one above the other. The patient may then, only too easily, be the sacrifice to a false diagnosis. The most distinguished authorities of all countries and of all times have made such mistakes. One example, of more modern date, will be enough.* The case was a fluctuating tumor in the axilla, which presented all the appearances of an inflammation of the cellular tissue, in which, however, pulsations were distinctly felt; they were considered as imparted, and the tumor held for an otherwise ordinary abscess. A first incision emptied pus. Then every doubt as to the nature of the tumor seemed dispelled. The bistoury was used a second time, going deeper, in order to widen the incision, at the same instant a powerful stream of bright, red, foaming blood spouted up, and shortly after the patient died. We ought never to proceed to the opening of a tumor about which the slightest doubt remains. The stethoscope will help us to detect the characteristic bruit of an aneurism which is wanting in abscess. The fine exploration trocar, or the acupunture needle are our last resort, and may be introduced into almost any doubtful tumor, without fear or danger.

Treatment.—Ordinarily the emptying of pus is the indication of nature. Only seldom, especially in anti-dyscrasic treatment, is it desirable to favor resorption by cathartics, mercurial ointment, painting with iodine, bandage pressure, etc. The opening of an abscess should not be delayed: 1st. When it is seated in the axilla, near the anus or the urethra, particularly when with fæces or urine pus is mixed. 2d. When the pus is situated deep, under fast fibrous tissues, as for instance, in the hand (also the fingers),

* Bardeleben, Chirurgie, vol. 1, p. 275.

the foot, deep in the thigh, etc. 3d. When, from the beginning on, important functions are interfered with by the situation of the abscess, *e. g.* in abscesses of the pharynx and isthmus faucium. Further, those abscesses should be opened early which threaten danger by their proximity to one of the greater cavities of the body, to the cavity of a joint, to important tendons or bones. The operative treatment of abscess resolves itself into punctures, incisions, setons, cautery and blisters. For most small abscesses a simple puncture with the lancet is sufficient. If there is great reason to fear the entrance of air into the cavity of the abscess, a subcutaneous puncture with a trocar is perhaps better, especially in deep abscesses. The entrance of air into wound cavities has gotten to be a great bugbear, and in the treatment of wounds in general, in which I have had a certain measure of experience, I have never seen any evil effects from it. A simple incision and splitting the pus cavity to about two-thirds of its greatest diameter, is oftenest employed in opening abscesses, and best fulfills the indication in phlegmons, perfect and quick emptying of the pus. The direction and place of the incision are readily determined by the form and situation of the tumor, the long diameter being the one usually chosen. The seton has the advantage of preventing the reclosing of the opening, but leaves an ugly scar. It was for Chassaignac* to improve upon the seton, and owing to him it has become almost obsolete in the treatment of abscesses in general. Our present system of wound drainage is based entirely upon his plan. Instead of the seton, he introduced long tubes of gum, with numerous openings through which it is intended the pus shall flow off, and through which injections can be made, if necessary, to cleanse or irritate a wound surface. The pus does not always flow well through this tube, especially when of a thick, sticky consistency, and in some cases the tube becomes clogged altogether, and the flow is interrupted.

Then free incisions, one on each side of the abscess, should be made at once, in order to obtain unobstructed open drainage. In fact, it were safer to adopt this plan in all swellings that require incision, throughout the whole domain of surgery. During my service on the surgical staff of the French army, in the Franco-Prussian war of 1870--71, we made counter-openings freely. Tubes were used but little. Oftenest not. If the tube is used, it is introduced fastened by a silk thread to an oblique opening (eye) in the point of the stilet. The trocar is first passed through the long diameter of the abscess, and the stilet, with thread and gum tube attached, drawn back, and thus it glides, without difficulty or disturbance of any kind, through the abscess.

Cauterization and blisters merit the lowest place, if they merit a place at all. The former was used, in one case of hot abscess of the cheek that came under my personal observation; the caustic used was caustic potash, the stick was taken and rubbed over the summit of the abscess until, in a second or two of time, the pus was entirely emptied. It is perhaps a little more painful than puncture or incision, but it leaves a very good, slight and symmetrical scar. This is the only advantage. It is well to employ it for this reason, when the patient is a woman, as the one mentioned was. Hot abscesses are usually single, although I had a case in which there were half a dozen of medium size in different parts of the body, which pointed, broke and healed without treatment, and so rapidly that treatment was really impracticable; they were brought about by too free living on the part of the patient, who had no further trouble as soon as put upon lower diet. The appearance of a small bead of pus on the summit of an abscess is usually regarded as signifying that it is ripe, but do not wait for this if the abscess is red, hot, and fluctuation is distinct. If there is reason to fear that the edges of the incision will close before the cavity of the abscess is entirely filled out, put a wad of charpie in. Emollient cataplasms aid in bringing hot abscesses to ripeness.

In cold or lymph abscesses the contents are, as the name indicates, of a serous or lymphatic character, translucent, with whitish-yellow, caseous flakes, shiny, thready, differing markedly from the pus bonum et laudabile of hot abscesses. Cold abscesses are soft, circumscribed, without pain upon pressure, lying not far under the skin, which retains its normal color. Fluctuation is easily felt. There is no inflammation in the surrounding tissue. The most frequent cause is a dyscrasia. If they grow very large they may, by pressure, then cause pain in the surrounding parts, in which case the skin above them becomes thin, dark red, and finally breaks through in one or more places. The watery contents already described then flow out, and a fistulous ulcer remains, that is very difficult to heal. If such an abscess remains long near a bone the latter suffers with it, becoming carious. It is our

* Traite pratique de la suppuration et du drainage chirugical, Paris.

first duty to treat the dyscrasia, and to think of local treatment only after the general condition of the patient has been improved; we may then try to bring the abscess to resorption, by means of spirituous frictions, painting frequently with tinct. iodine, bandage pressure, cold douche, and, according to Velpeau, blisters. If these do not succeed, and the general health of the patient is better, we may proceed to open a cold abscess, especially if it threatens to break out itself, or threatens a bone by its proximity. It may be opened upon any plan we please, as in this case it is inflammation that we wish to induce, and not to avoid. The same general precautions and rules are applicable in cold as in hot abscess, as regards operative measures. The injection of exciting and irritating medicaments after the opening of the cold abscess with the lancet, is suggested.

Schaack injected red wine or a solution of sublimate or caustic potash; Rust, boiling water. If, after the opening of the abscess, the skin that covers it is very thin, bluish, or near death, it should be cut away with scissors in its entirety, and the wound treated according to remaining indications, generally with stimulating dressings.

Hospital Reports.

UNIVERSITY HOSPITAL.

CLINIC OF JOHN ASHHURST, M.D.

Professor of Clinical Surgery in the University of Pennsylvania.

Reported by Louis J. Lautenbach, M.D

Case 1.—Enlargement of the Prostate.

This man, somewhat beyond middle age, has for some time past noticed that he passes his urine more frequently than he formerly did. He has also noticed that he is required to strain, and that the passage requires a longer time. He has noticed a scalding sensation in the head of the penis, with neuralgic pains in the same region.

The stream which he makes is not propelled with the ordinary degree of force, nor does it have the normal parabolic curve; it comes out slowly and shows no evidence of a propelling force, and falls almost perpendicularly. In stricture of the urethra the stream is narrow, but it is propelled by the ordinary degree of force, and has the ordinary parabolic curve. In enlargement of the prostate there is often no diminution in the size of the stream, but as the propelling force is lost the urine drops vertically.

In order to prove the supposition of enlarged prostate, it is necessary to make a careful examination of the urethra, especially of its prostatic portion, and of the bladder, where we shall probably find a small quantity of residual urine, that is to say, of urine which always remains in a bladder, which cannot be completely emptied. This man has passed water one hour ago, so that if we find urine present in the bladder, its amount will be a moderately fair test of the amount of residual urine. In cases of prostatic obstruction there is usually not much difficulty in introducing an instrument, but sometimes, on account of the curve of the prostatic portion, there is present an obstruction to its introduction. In order to overcome this it is sometimes necessary to use an instrument with a considerable curve. Passing up the catheter we find the prostate enlarged. The amount of enlargement of the middle lobe is not considerable, but the lateral lobes are quite large. Passing the catheter into the bladder, we do not find a very great amount of urine, not as large an amount of residual urine as we frequently see, but it comes out without any force, simply dropping from the end of the catheter. There is enlargement of the prostate without any stricture.

Our patient tells us that he is able to empty his bladder without much trouble. It is very fortunate for him that the obstruction is not of such a form as to interfere completely with the evacuation of urine.

It is very important, when there is much residual urine, that the patient's bladder be completely emptied by catheterization once or twice a day. To relieve the symptoms of which he complains, which I believe to be entirely due to enlargement of the prostate, we will use ergot, which causes contraction of the unstriated muscular fibres, and has been extensively used in enlargement of the prostrate with very good results. If it, however, should occasion bad symptoms, then it will necessarily have to be abandoned, and something else substituted for it.

Case 2. Traumatic Stricture of the Urethra; External Perineal Urethrotomy, without a Guide.

We have in the house a man, whom I carefully examined the day before yesterday, with a bad stricture of the urethra, a traumatic stricture, occasioned by a fall a long time ago. Retention of urine is not present, but there is almost retention; the urine has been constantly dribbling for the last five or six years, gradually becoming worse.

In these cases, before attempting any operation, an examination of the urine must be made, with the view of throwing some light on the condition of the internal organs, and also for the determination of the prognosis. If by this examination evidence of an advanced disease of the kidney is developed, we would not attempt to perform the operation which I propose to do today, because the risks would be too great. If there was advanced disease of the kidney, we would, instead, puncture the urethra behind the stricture, to relieve the bladder, and then trust to being able to pass an instrument at some future time, or allow the patient to remain with a fistula.

The urine has been carefully examined; its specific gravity is 1.020, with a strong alkaline reaction; there is a mere trace of albumen.

The sediment is composed of ammonio-magnesio-phosphate, mucus and pus corpuscles, vesicular epithelium and a few granular casts. From

this examination there is no doubt of the bladder being diseased, and this is aggravated by the ammoniacal condition of the urine, this ammoniacal condition being also increased by the further progress of the cystitis. The two conditions mutually react one on the other. Besides the condition of the bladder, there is undoubtedly some disease of the kidneys; in fact, it would be impossible for him to have stricture so long without its having caused some disease of the kidney. Such examinations of the urine, although of great value, are yet subject to error; that is, a negative result may give rise to the supposition of there being no renal disease. In some forms of kidney disease, however, no albumen or tube-casts are found, and it is just one of these conditions which is often connected with a condition of stricture such as is here present. The interstitial form of suppurative nephritis often gives no evidence of its presence by the urine, and is very apt to be connected with strictures. As we have no further data, however, we must trust to the examination, which leads us to the supposition that there are no marked changes in the kidneys. In this case, therefore, it would not be proper to refuse this patient the best chance which he would have if his kidneys were healthy.

The operation which I consider that it will be necessary to perform here, is that of external urethrotomy; but if I can get an instrument in the urethra to pass the stricture, I will then split the stricture. The latter method, the introduction of an instrument and the splitting of the stricture, is attended with much less danger than the operation by section. There is, in the first place, some risk of hemorrhage in the section method, both primary and secondary bleeding being occasionally met with. Besides the risk of hemorrhage there is the further risk of increasing any existing disease of the kidney, causing uræmia, and there are all the dangers incident to other operations of the pelvis, peritonitis, etc.

We must first make a very careful examination and endeavor to get an instrument into the bladder. The smallest instruments we have are the filiform bougies, which, while of great value, sometimes lead to error, the instrument appearing to have passed the stricture, when in reality its end has turned upon itself. During the examination, keep the patient as warm as you possibly can. First introducing a metallic instrument—a good one to begin with is a No. 15, French scale—into the urethra, we touch the dense cicatricial tissue which constitutes the stricture. This instrument will not pass, and we must go down in the scale, being careful to remember that metallic instruments of very small size may prove very dangerous. Unless skillful, I would not advise you to use such instruments any smaller than a No. 11 or 13 of the French scale, as otherwise you will be apt to produce false passages. In this case there are as yet no false passages, which is favorable. I will now try a No. 7, French scale, which is a dangerous instrument. Although I turn the point in different directions, it does not seem to catch anywhere. Usually the opening in a stricture is not at the centre, but at one side, and if the point of the instrument only presents at the centre, there is but little chance of entering. Using now a No. 6 French scale, with great care, I still fail to enter, and am compelled to resort to the filiform bougies, but with these also am unsuccessful, the end of the instrument turning on itself. Sometimes by giving the end of the bougie a corkscrew turn, it can be made to enter the stricture, but here this also fails.

The only thing that now remains to be done is to perform the operation of external perineal urethrotomy without a guide, the old fashioned "perineal section." Had we been able to get even a filiform bougie through the stricture we could then have used the ingenious instrument suggested by Prof. Van Buren, of New York, and widely popularized by Prof. Gouley. It consists of a catheter, grooved on the back, the end of the groove being bridged over so as to form a tunnel. The tunnel end of the instrument is slipped over the end of the filiform bougie, and thus passed around the bougie, through the stricture, when it can be used either as a catheter or as a staff.

In performing the operation of external urethrotomy you want to get all the light you can. The patient is placed in a lithotomy position and an ordinary staff, passed up to the seat of stricture, is held firmly in the median line by an assistant. The incision for the exposure of the urethra is made in the median line, being careful not to begin further front than necessary, making the incision from an inch and a half to two inches long. The incision is to be carried directly down to the staff. When this has been done you can sometimes make the instrument pass the stricture without further trouble. In order to draw the edges of the wound apart, I am in the habit of using aneurismal needles held by assistants. Feeling now for the groove of the staff, you cut directly down upon it, thus opening the urethra in front of the stricture. Now hunting for the opening in the stricture, a grooved director or a probe is passed in, and the stricture slit up, when immediately a sound can be passed into the bladder; now passing in a catheter at the meatus, the instrument is guided by the grooved director into the bladder. The catheter is left in the urethra for five or six days, that the parts may be moulded about the instrument, as it were, thus facilitating its re-introduction when it is removed. After that time, the catheter is withdrawn and a full-sized sound passed every three or four days. The catheter is secured by means of adhesive strips attached to the skin of the penis itself. Fasten a few strips down along the sides of the penis clasping the catheter, then make these secure by a few circular turns of adhesive plaster about the catheter and a few turns around the penis, being careful not to make the latter to tight.

In this operation we are not obliged to cut any very large vessels, and in consequence, there is usually not much bleeding. The operation, if carefully performed, is not in itself very dangerous, and in the majority of fatal cases death has been caused, not by the operation, but by previously existing visceral disease. It will be necessary for the patient to use the catheter occasionally after he leaves the hospital, in order to keep the urethra dilated, and thus prevent a recurrence of his stricture.

MICHIGAN COLLEGE OF MEDICINE.

CLINIC OF PROF. LA FERTÉ,

Prof. of Anatomy in Michigan College of Medicine.

Mr. A., æt. forty five, whose hand was bruised between two cog wheels.

Gentlemen, I bring this case before you that you may form your own opinion as to whether this wound is healing properly or not.

Suppose we had necrosis of the bone, how would we find it out, or how would we know it? We would know by the sensation we felt on examining it with a probe. We want to know when a wound is doing well, and when it is not doing well; these are points which are very important.

As I said before, we know when there is necrosis, by the grating sensation. Now what causes this grating sensation? It is caused by the bone being denuded of its periosteum; in health the bone is covered by periosteum, but when it is denuded there is necrosis, and you have a rough, uneven surface of bone. We have another disease of the bone, ulceration, in which the surface is not nearly so rough as in necrosis. In ulceration of the bone it is covered with disintegrated bone, somewhat like sand, which is not the case where there is necrosis. In hip joint disease, third stage, where sinuses exist leading to dead bone, you give an injection which is known to possess the property of being capable of removing this material from the surface of the ulcered bone. Now, when you have removed this sandy material from the bone, you have a clean surface and granulation goes on more favorably. In soft parts it is just the same; in soft chancre there is a covering of gray material; to treat the case properly we first dry the ulcer, make use of escharotics, for the removal of this gray material lying over the surface of the ulcer; you now get a clean surface, then stimulate, and granulation goes on nicely. If we had dead bone the edges of the granulation around this wound would be spongy; very characteristic where you have a good deal of dead bone. Where you have a sinus in hip joint disease the margins, according to some pathologists, resemble a hen's anus that is reverted. We will stimulate this a little, it seems to be rather sluggish; you notice these spongy granulations above the integument, sometimes called proud flesh; we will destroy that.

Case 2.—Mr. B., æt. twenty years, who had a deep cut on the ball of the thumb. Gentlemen, here we have a wound, which will heal by granulation or second intention. In a young child with such a wound, we would expect healing by first intention. Some pathologists say, in very young children, the wound can unite by direct adhesion of the surfaces to one another without any inflammation. In first intention there is a certain amount of inflammation, but that inflammation does not run on to suppuration.

The majority of pathologists deny that we can have healing without a certain amount of inflammation, no matter how young the child may be.

In all wounds that heal by granulation, we have a certain amount of serum thrown out; this serum becomes changed into pus; a few hours after the margins of the wound are brought together, you will find along the edges a certain amount of swelling, afterwards the swelling disappears; this swelling is caused by irritation of the blood vessels. The blood vessels become dilated, this dilatation of the vessels produces expansion of the walls, then, as a consequence, they are thinner, and blood cells will be thrown out After a while this infiltration will be absorbed, when the swelling will disappear and granulation progresses.

These granulations, you will find, are little red dots scattered over the wound; touch one and the patient experiences pain; but whether these bodies have nerves penetrating into them subcutaneously, or simply lying under them, is a disputed point. Blood vessels are freely distributed in these bodies.

From your knowledge of pathology, you will understand that where there is a great deal of swelling we have considerable serum thrown out, and excessive suppuration may take place. As we have commenced with the cold water dressing in this case, we will continue it. Now, what action do we expect to get from the cold water? It will contract the blood vessels, prevent an excessive amount of serum being thrown out; consequently less pus will be formed and granulation take place more rapidly. These stitches we will leave in for four or five days.

Case 3.—Gentlemen, what is the diagnosis of this case? "A swelling, the result of sprain." Now what is a swelling? "Œdema." What causes that œdema? "Effusion." This effusion is characteristic of what? "Inflammation." Now, according to your theory we have inflammation. Is that inflammation in the synovial membrane of the wrist joint or on the dorsum of the hand? "It is on the dorsum of the hand." What other name for inflammation of the cellular tissues? "Cellulitis." Would that cellulitis cause the joints to be stiff? "It would." A filling up of the space between the bones and the integument will prevent the fingers from bending. There is not very much œdema to these fingers, but on the back of the hand is considerable stiffness. What is the stiffness of a joint called? "Ankylosis." For example, in fracture of the leg, there will be stiffness from disuse, inability of the person to move himself. When he tries to move the joint finds firm resistance. What kind of ankylosis do we call that? "Fibrous ankylosis." Sometimes the adhesions are very strong in the joint, when surfaces become knit together so that there is scarcely any motion at all. In all cases of this kind you put the patient under chloroform, all muscular action becomes dormant, and you are able to distinguish between bony and fibrous ankylosis.

Here is a rule to guide you: Always, wherever there is the slightest amount of motion, you may rest assured that the ankylosis is fibrous, no matter how slight the motion; when bony union exists in a joint it is entirely immovable. In bony ankylosis, you may have to chisel out a piece of the bone, in order to bring the limb into a more favorable position. In fibrous ankylosis in the knee joint, for example, you break up the adhesions by force, and follow that up by passive motion every other day, as the case might be. In these cases you will have considerable inflamma-

tion in the joint. You subdue this inflammation by lessening the flow of blood to the part. This is done by pressure on the femoral artery, which will regulate the supply of blood to the part. When you use pressure, watch the patient very closely, for fear of gangrene setting in below the point of pressure. What will we do in this case? Use absorbent remedies; muriate of ammonia, thirty grs. to ℥j; apply a bandage and keep the bandage wet with a solution of thirty grains of the muriate of ammonium to the ounce of water. Also use passive motion, with the hand in an elevated position, to break up the adhesions.

Medical Societies.

TRANSACTIONS OF THE OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated meeting, Thursday, November 2d, 1881, the president, Dr. Edward L. Duer, in the chair.

Dr. Robert P. Harris exhibited twenty-three casts of female bony pelves, illustrating the varities of deformity affecting labor. They were obtained in Paris, by Dr. T. Hewson Bache, for the Museum of the College of Physicians.

Purpura Hemorrhagica.

Dr. Henry Beates related the history of a child, healthy for the first four months of its life, at which age it was attacked by thrush; ten days later an ecchymosis of purpuric character appeared on one leg, and a few days later spots of the same character appeared over the body; on the fifth day the stools were tarry, showing intestinal hemorrhage; a bronchial secretion was also stained with blood; on the seventh day a hemorrhage started from an abraded spot on the perineum; various local styptics were applied to this spot without result, until a red hot needle was used as a cautery; on the tenth day a hemorrhage occurred from the canthus of one eye, and on the fifteenth day the child died, from exhaustion. At the autopsy the internal organs were found quite exsanguine.

Bursting Pelvic Cyst.

The patient had been for some time in poor health. Nine months ago she observed a tumor in the right iliac region. On one occasion, after slight exertion, she felt something give way; this was followed by intense pain and collapse; she recovered, and has had no return of the tumor.

Hemorrhagic Diathesis.

Dr. Wm. Saveny related the history of a boy, five years of age, who had fallen and received a slight wound of the scalp from a nail sticking out of a post; it was a mere scratch, and did not need a stitch to hold it together, but it bled profusely; all sorts of domestic remedies, including cobweb, had been tried, without avail. The doctor finally succeeded with lint, wet with Monsel's solution, and continued firm pressure. A few days later the same boy fell off of one step on to the floor, there was no external wound nor loss of blood, but the side of the face was enormously swelled, from hemorrhage into the tissues. A course of iron and tonics has improved the boy's appearance, but he is still pale.

Dr. Harris inquired if there was any history of hæmophilia in the family? Had the boy large knee-joints? There is a hemorrhagic diathesis entirely distinct from true hæmophilia. The latter is rare in cities, but is more frequent in the country. The descent is through the females of a family, but the disease appears only in the males; the Jews in certain districts of Germany present many examples. There is a remarkable family near Elkton, Md.

Dr. Saveny replied that there were no evidences of hemophilia in the family. The mother was pallid, had red hair, but did not lose much blood in labor.

Dr. Horace Williams had seen a case of obstinate and prolonged hemorrhage after the extraction of a tooth; it was finally stopped by fitting a cork into the alveolar cavity. An infant, aged nine days, was attacked with purpuric spots over the body and bleeding at the naval. To the latter were applied, successively, styptic colloid, tannin, Monsel's solution, Monsel's salt, in powder, and finally, transverse pins and figure-of-eight ligatures; but the bleeding reappeared as soon as the latter came away, and the child finally died from loss of blood.

Dr. R. A. Cleeman had under his care a young man who had previously suffered from profuse hemorrhage for two days, consequent on the extraction of a tooth; the hemorrhage was finally stopped by Dr. Hartshorne, who plugged the cavity with a styptic. Dr. H. advised the young man never again to run the risk of a hemorrhage of any kind, as it would probably prove fatal. Recently he had been suffering severely from a toothache which nothing but extraction could relieve. Dr. Cleeman put him on gallic acid internally, and tannic acid locally, for two weeks before the extraction, which was accomplished without any unusual loss of blood.

In a case of nasal hemorrhage, the anterior and posterior nares were plugged, but then ecchymoses appeared around the eyes, and the plugs were removed; transfusion of a few ounces of blood was employed, and the hemorrhage ceased and did not return; the patient died three months later, of phthisis.

Dr. E. L. Duer considered gallic acid a very valuable remedy for hemorrhage. He would like particularly to bring before the Society the old but neglected remedy, erigeron, or fleabane; the tincture and the volatile oil are very efficient, when used internally, to stop hemorrhage. The oil may be given in doses of ten drops every ten minutes until the bleeding is checked, after which it may be continued at longer intervals until the tendency has passed away.

Dr. Githens had been using oil of erigeron for a number of years, with remarkable success, as an internal hæmostatic. It was far more reliable than any other with which he was acquainted.

Imperforate Rectum.

Dr. Githens had performed an autopsy this afternoon upon a baby, aged twelve days, that had died from occlusion of the bowel. The

anus was perfect, but as no meconium was passed an examination of the rectum was made; the latter was found to be a cul-de-sac about one and a half inches in depth, as a tumid swelling could be felt above; a nick was made at the upper extremity of this cul-de-sac, and gas and meconium escaped; two days later it was found necessary to enlarge this opening, but at no time did any solid fecal matter pass nor did the color of the milk appear in the fæces. Death occurred from collapse, from escape of the contents of the bowel into the peritoneal cavity. At the autopsy the rupture could not be found; the transverse colon was filled with well digested milk, the upper part of the descending colon doubled sharply on itself and was bound down tightly to the posterior wall of the abdomen, there being no meso-colon on the left side; the lumen of the colon at this point was also obstructed by an exaggerated valvula conniventes (?) which formed a septum reaching half across the colon, and had prevented the passage of the solid portions of the fæces below that point; the rectum was distended with some liquid, dark, fecal matter.

A very remarkable circumstance in connection with this case is the fact that a former child of the same parents died at the end of the third day, there having been no discharge from the bowels; and the mother's aunt on her mother's side, had lost five children out of seven from the same cause; one of the five had been operated upon, but the condition returned after the lapse of six months.

Report of Microscopical Examination of Specimens presented at the last Meeting by Dr. Wm. Parish; by Dr. H. Beates.—The specimen removed from the cervix uteri of case No. 2, is carcinoma, of the encephaloid type. The small tumors taken from the uterine cavity of case No. 1, for the relief of continued hemorrhage, prove, on section, to be hyperplastic glandular utriculares, mucous membrane and parenchyma. The intimate relationship of the uterine mucous membrane with the muscular structure is clearly shown, and the features of clinical interest in this instance well demonstrated. The mucous follicles or glands located on the free border in considerable number, indicate that the growths originate from the fundus. The follicles are the seat of active epithelial proliferation and papillomatous degeneration, which latter process, it may be remarked, is *not* characterized by the regular relationship of cells to vessels, seen in typical or benign papilloma, but by large multinucleated, irregularly-shaped cells, arranged in groups, without any apparent regularity or system. This condition is strongly suggestive of carcinoma. The leso-fibres are found to be infiltrated, in many places, by proliferated epithelium cells, showing that the morbid process involves the parenchyma.

—To promote the cause of temperance in Germany an attempt is to be made to establish coffee-taverns for the poorer classes, similar to those opened in this country. A society has been formed with this object, and a meeting to carry it out has been held, at Frankfort on-the-Main.

COLLEGE OF PHYSICIANS OF PHILADELPHIA.

Clinical Observations on Albuminuria, Based upon a Study of sixty-two Cases in Private Practice.

BY ARTHUR V. MEIGS, M.D.,

Physician to the Pennsylvania Hospital.

(Read October 4, 1882.)

During the last eight or nine years it has been my habit to keep a record of the examinations of urine I have made. That record now contains notes of between sixteen and seventeen hundred examinations, and a study of it recalls to my mind, with more or less distinctness, the histories of sixty-two persons suffering with albuminuria.*

In a number of instances I have been able to follow cases for a series of years; from this circumstance in particular, the number of years the patients were under observation, I have been enabled to satisfy myself of some clinical facts, particularly in reference to the diagnosis and prognosis in this complaint, which I hope may be worthy of your attention.

That which has most impressed me is the impossibility of making a prognosis, with any degree of exactitude, in most cases of Bright's disease. Of course, in the plainer ones, the decision is easy; if asked an opinion in a case with a large, or even moderate amount of albumen in the urine, with increasing heart failure, and evident decline of strength and vitality, with headaches and the peculiar white complexion of the disease, it is easy to prophecy that such a person will not live long, and the prophecy, nine times in ten, comes true; if called, however, to decide questions of the future for a young man of thirty-two or three, previously well, but for some weeks complaining of headaches, malaise, and boils, and then examination of the urine shows a slight amount of albumen, granular and hyaline casts, and abundance of rather small oxalates, the question of the future is not so easily decided. I have seen such cases go on pretty well for a few months, then suddenly have convulsions, and die in a few days. Again, persons presenting identical symptoms, after being sick a few weeks or months, entirely recover. To my mind it is impossible, in the present state of our knowledge, to anticipate the future, and the patient should always have the benefit of the doubt, and be shown the brighter rather than the darker side of the picture

I know of three persons in whose urine I found albumen and tube-casts, accompanied with all the other signs of Bright's disease, more than eight years ago, who are yet alive. One is a lawyer in easy circumstances, who was taken sick in January, 1874, when he was fifty-six years of age, with what appeared to be a bad cold, but he had extreme dyspnœa and excessive restlessness and nervousness, although he is usually very self-composed. The dyspnœa seemed greater than could be accounted for by the extent of disease of the lungs, which amounted

* Many of these cases occurred in the practice of my father, Dr. J. Forsyth Meigs, but a large majority of them I saw from time to time myself.

only to a moderate bronchitis; the urine being examined, it was found to contain a trace of albumen, some blood, and tube-casts. It should be said that this man had suffered in previous years with attacks of gravel, when he would pass blood and small calculi. Nearly four years afterwards there was still a trace of albumen in the urine, and granular casts, showing that the condition was by no means merely temporary. Ever since he is liable to severe colds, and always suffers more than common with oppression, although it usually takes the form of a common coryza. He is now sixty-four years old, and an unusually young-looking, active man of his years.

In contrast with this case, a woman of about sixty was seized in the night, having gone to bed apparently in her usual health, with an attack of oppression, and what her physician called congestion of the lungs, so violent that it was thought she would die at once; she, however, rallied by morning. An examination of the urine, made a few days afterwards, revealed the presence of a slight trace of albumen and casts. Four months afterwards there was still a trace of albumen in the urine, and granular and fatty casts, although she was up and about as usual, being merely very weak, having no apparently urgent renal symptoms. At a later examination the trace of albumen was still found, but no casts. About seven months from the first discovery of the disease she had another violent attack of oppression, and died in a few hours. Now what are the points to distinguish these two cases? One died after a few months' illness, and the other, having had apparently the same complaint and almost identical symptoms, is, after eight years and a half, still alive, and apparently, unusually well for his time of life.

In December, 1874, a lawyer in full practice, then about fifty four years of age, was taken with an attack of acute catarrhal pneumonia, and was also found to have albumen and tube-casts in the urine. He was sick all that winter and the following spring, the urine constantly containing albumen and granular and hyaline casts. The albumen and casts were found in the urine during 1875 and 1876, and part of 1877. On May 2d, 1877, about two and a half years from the onset of the disease, there was at last no albumen found, and the microscope revealed nothing abnormal. Since that time, although the urine was examined in 1878, 1880, 1881 and 1882, there has never been found either albumen or tube casts, and the patient now a man sixty-five years of age, enjoys very good health, having had no return of the disease in more than five years.

The third case is a woman, whose father, brother, and two sisters have died of the same disease. She has had a trace of albumen and hyaline and granular casts in her urine since March, 1874, when she was about thirty-one years of age. I have records of this condition in 1874, 1876, 1879, 1880, 1881, and 1882. In February last she caught cold, and seemed for some time on the verge of a severe renal attack, having coryza, so that her nose was almost entirely stopped, and there were bronchial râles heard in the chest, but an amount of dyspnœa, seemingly out of all proportion to the extent of the disease, that could be detected by physical exploration; the albumen in the urine also increased very much in quantity. In some weeks, however, she recovered, and this summer seems in her usual health.

The father of this patient had a severe attack of hepatic colic, and passed several gall-stones, in 1877, but afterwards he continued in pretty fair health for some time. On May 9th, 1879, a trace of albumen was found in the urine; this continued to be present at succeeding examinations, but no tube-casts were found at this time or afterwards, although they were carefully sought for, and about December, 1880, eighteen months from the original discovery of his disease, he succumbed to an attack of uræmic convulsions, being seventy years of age. A son and two daughters of this man died of the same disease some years before. The son, after having had dropsy, lived for several years in tolerable comfort, until a severe cold proved fatal. With the history of this son and one of the daughters I am not familiar, but the third one I saw, and she died in convulsions. The condition of this person before her final illness, which lasted only a few days, was in no way different from that of her sister, who is still living, and has had the disease for nearly nine years, and the attack which the surviving one had last March was exactly like those of which I have frequently seen other people die.

I maintain, therefore, that with our present knowledge it is impossible, in doubtful cases, to prognosticate what the result will be, and that for the patient and his family, as well as for the credit of our profession, we should be very guarded in our prognosis. The presence of albumen and tube-casts in the urine, even when found for so long a time as two years continually, is not, as shown by one of the histories I have detailed, a reason why we should necessarily give a fatal prognosis, and this is particularly the case when the patient is a person past middle life. In the face of such authorities as Beale and Grainger Stewart, many practitioners think the microscopists can better judge (by examining the urine) of the stage and form of Bright's disease they have to deal with than they themselves can. Grainger Stewart is emphatic upon the subject. On page 271 of the American edition of his work on "Bright's Disease," he says: "Some authors attach great importance to the tube-casts. They are of undoubted value in establishing the existence of Bright's disease, considered generically, but they afford comparatively little assistance in the differential diagnosis of the different forms. Any form of tube-cast may occur in any form of the disease, and at almost any stage. Indeed, all the leading varieties may occur simultaneously in one case." Beale says (Kidney Diseases, Urinary Deposits and Calculous Disorders), "Dr. Basham thinks he can judge of the stage of Bright's disease by the character of the urinary sediment. I wish I could agree with him in this conclusion. The more carefully the matter is investigated the more convinced am I that it is unsafe in many cases to attempt to draw inferences as to the stage of the disease from the character of the urinary sediment only. Nothing but a careful

consideration of every point connected with the case will enable us to arrive at a general conclusion concerning the state of the disease. . . . Dr. Basham says: 'The most untractable and hopeless form of *morbus Brightii* is that represented by the presence of the fatty or oily cast.' This statement requires some qualification, for although it is quite true that some of these cases are terribly and rapidly fatal, it must be admitted that some live for twenty years or more, and die at last of other disorders." With regard to the presence of oily casts in the urine, and it is upon their discovery that microscopists found their gravest prognosis, Dr. George Johnson says (Lectures on Bright's Disease, New York, 1874), "The appearance of oily casts and cells excites less alarm now than it formerly did. It indicates that in certain parts of the kidney the secreting cells and inflammatory exudations are undergoing fatty transformation; but I have seen many cases of complete recovery after oily casts and cells in great numbers had appeared in the urine continuously for many weeks."

A very common symptom of renal disease, and one upon which there is not much stress laid in the majority of books upon the subject, is dyspnœa. Whenever a patient is found suffering with dyspnœa, and particularly if there is great nervousness, and loss of self-control, and anxiety, with no other fully sufficient cause for its existence, suspicion of renal disease should be aroused, and the urine examined, even if there are no other symptoms whatever pointing toward a lesion of the kidney. These attacks of dyspnœa frequently come on with great suddenness in persons who have not considered themselves sick, and such attacks are often quite rapidly fatal. This condition has been described as renal asthma, but I believe it much more common than is usually supposed. Another symptom of Bright's disease, which I have frequently noticed, and have never heard described, is coryza, of such a character that it gives rise to very much greater distress than any ordinary cold in the head; with this there is not much discharge from the nose, but the patient complains that he can get little or no air, except through the mouth, this being accompanied with excessive oppression, much more than the condition would seem to warrant. This symptom was first called to my attention by my father, Dr. J. Forsyth Meigs, in a case we saw together about nine years ago.

The suddenness of the onset, or perhaps it would be more correct to say, of the discovery of the existence of this disease, is often very great. In one instance, I knew of a young man, previously supposed healthy, seized with a convulsion while sitting at the supper table, after he had finished his day's labor as a wagon driver; this was followed by others, and the case ended fatally in a few days. In a second case, I was called upon by a young woman to explain a swelling of the vulva, with which she was suffering; examination of the urine revealed the existence of a large amount of albumen; this continued for some time, but after prolonged use of iron, her condition improved, and she had apparently fair health, until about two years later she became pregnant, and died within a few days after the birth of her child. In a third case, a man fifty-four years of age was seized in the night with epistaxis, a thing he had not had since he was a boy; examination of the urine revealed the cause, and about six weeks later he was found one morning, insensible, in the bath tub; examination showed that he had right hemiplegia, and he died in three days; a vessel in the brain had ruptured, presumably from the same degeneration which six weeks earlier had caused the nose to bleed. On the other hand, the insidious nature of this disease and of its onset is a matter of such common report, that I will not weary you with any cases illustrative of this fact.

The existence of oxaluria, or of uric acid lithiasis, is a prolific source of mischief to the kidney. The deposit of oxalates, or uric acid in the kidney, and its passage outward, occurs most frequently in persons who are large eaters, living an inert life, and taking but little exercise. Such people are common among the rich in large cities, and I have seldom failed to find tube-casts in the urine of any one who passed gravel for any length of time, whether oxalates or uric acid, even if the calculi were microscopic in size, and this commonly before any albumen was to be found. Later, if there is any considerable amount of gravel passed, albumen and blood will be found in the urine. If the attacks of gravel occur often, they are apt, at last, to be followed by Bright's disease, directly caused, probably, by the mechanical irritation of the lining membrane of the tubules of the kidney, by the sharp edges of the minute calculi passing through them.

It cannot be proven by statistics, and yet I think there is strong ground for believing, that the proportion of deaths caused by affections of the kidney is greatly on the increase. The tendency of modern life seems to be such that a larger number of deaths are caused by degenerative processes, and less by acute disorders. In former times, children were less delicately reared, and a larger proportion of the frailer ones, probably, died from exposure and want of care; now, beginning at childhood, and continuing up to old age, we are much more careful to avoid exposure, and are more self-indulgent, at least, as far as our bodies are concerned. Who, in modern times, except the professional athletes, would undertake the physical labors of the Emperor Charles V, of Germany, of whom Motley says, that he was able to tell, at a time when all journeys were made on horseback, or by boat, "of his nine expeditions into Germany, six to Spain, seven to Italy, four to France, ten to the Netherlands, two to England, as many to Africa, and of his eleven voyages by sea!" Now-a-days, the majority of city men are in their places of business all day, and take but little exercise, eating as much and as rich food as in former times, and drinking not a little withal. The natural and necessary consequence follows, that after years of this kind of life, the excretory organs degenerate; first the kidney, which is the common sewer of the body, and, like the heart, has to do continual work, from the hour of birth until the hour of death. It is a common thing, in modern life, to see a man naturally robust and gifted with a large appetite, become more inert

as years go by, when he will gradually give up his active exercise, until finally he takes none; still the eating and drinking go on, and he becomes fat and sluggish; finally he loses health, and then examination shows that degeneration is beginning in the kidney. I could instance several cases of the kind, but my space will not allow me.

The drift of my paper has been to try to establish that we should, in all ordinary cases of albuminuria, be very guarded in our prognosis, except when it is self-evident that the case must be rapidly fatal. I have now under observation, fifteen persons, seventeen, if I count two who have albuminuria alternating, or parallel with, diabetes mellitus, who have been suffering with this complaint for a greater or less length of time. With three of them the disease began nearly nine years ago, and they either have it now, or have entirely recovered from it, after more than two years' continual duration; yet in regard to no one of them do I feel able, even in my own mind to guess, much less to formulate an opinion, as to how much longer they may live. There are absolutely no data, if such cases are considered in the light of the experience of the sixty-two I shall mention, upon which to found a positive prognosis.

Another observation I have made, is in regard to the death of very old people. We are all agreed, I presume, that when a very old person dies, and we report the death as one of old age, it is because we are unable to put the finger upon the exact part of the old and worn-out machinery that at last refuses to work, and thereby causes all the rest of the mechanism to stop. This direct cause, if sought for, will frequently be found in the kidney. To examine the urine is not always a thing that strikes us, particularly when absolutely no symptoms appear to point toward kidney disease. I have seen a number of instances in which old people seemed to be fading out, as they often do, yet have felt entirely unable to explain to myself any direct cause for the failure, until the urine was examined, when there was found albumen, with granular and hyaline casts, and sometimes a few blood corpuscles. A careful inquiry would perhaps reveal the fact that the amount of urine passed was very small; all this without any other symptom to point toward kidney disease; at the same time, the failure of the patient being very gentle and gradual: or else, as not unfrequently has happened, senile delirium existed, either violent or mild in type, followed at last by death.

In the whole sixty-two cases which I will now summarize collectively, there have occurred twenty-six deaths, thirty-four are, to my knowledge, still living, some in better and some in worse health, and of two I have lost sight.

Five were cases of ordinary acute desquamative nephritis, with the occurrence of one death and four recoveries. In one instance, a child, there were two attacks, two years apart, the first being unaccounted for, the second following scarlet fever; the second case occurred after scarlet fever; the third after diphtheria; the fourth was in a young man, apparently healthy previously, and now in good health; his attack only lasted a short time; the fifth and fatal case was in a boy of about fifteen years of age, and came on while he was at boarding school, the onset being insidious, and the disease progressing from bad to worse until death occurred.

Four cases seemed to be caused by the passing of gravel, principally oxalates. These people are still all living, although they have had albumen and casts present in the urine, on and off, for varying lengths of time; two of them for six years past, one for seven years, and the fourth has had two attacks of nephritic colic, about a year apart; on each occasion, albumen and granular casts, uric acid and blood corpuscles were found in the urine.

Twenty-two cases I class as of ordinary Bright's disease, there being probably contracted kidney in the majority of instances, and of them, fourteen are dead. I made no post-mortem examination in any one of these cases. In most of these cases (seventeen of them) the onset was insidious, there being no illness to mark the beginning of the disease; in one, the patient was seized with a convulsion at the supper table, having been supposed previously to be in good health; in a second, there was a violent attack of congestion of the lungs, with terrible dyspnœa during the night, the patient, a woman, having gone to bed thinking herself in good health; in a third there was dyspnœa and congestion of the lungs occurring suddenly; in a fourth the condition of the kidneys was discovered concurrently with an attack of catarrhal pneumonia; a fifth was a man who had had attacks of nephritic colic. He had a violent attack of congestion of the lungs, with bronchitis and dyspnœa, and was found to have albumen and casts in the urine, which condition continued, on and off, for four years; he is now in apparently good health, although the first attack was nearly nine years ago. Of these twenty-two cases, two were in one family, one soon dying, and of the other I have lost sight: two in another family, one dying and the other, I think, being still alive, although the disease was discovered three years ago; five cases occurred in another family, the father, son, and three daughters. The father and mother of this family had ten living children, five reaching adult life, one died of consumption, and the other three, and the father, of Bright's disease, the surviving daughter has had the disease for nearly nine years. In another family there were three cases, all women; one died, having had uræmic convulsions, and the other two still live, both having had the disease for about three years. A brother has now cancer of the rectum. The mother is still alive, and although seventy-four, enjoys good health. The father died at quite an advanced age, but I do not know of what disease.

The next twenty-two cases I must classify as unaccountable; eighteen of them occurred in persons over sixty years of age, and the other four were well on in life; one was over ninety, three over eighty, and two over seventy years of age. Of these people only five are dead, and of the five fatal cases, one was the man over ninety, two were over eighty, a fourth was seventy-seven, and the fifth sixty-seven.

The next four cases were of people advanced in life, and they died of general break-down, having in three instances concurrent disease of the heart and kidneys, with implication of the lungs, and the fourth had renal and brain disease.

In two instances there has been albuminuria with diabetes mellitus; in one, sugar was discovered in the urine six, and in the other four years ago. Since then there has been sometimes sugar, and at others albumen, at times both at once, in the urine of these two women. In neither instance have tube-casts ever been found. I mention these two cases in a paper on albuminuria, because both have frequently had albumen in the urine, and I confess myself unable to explain the phenomenon, the quite frequent presence of albumen in the urine, without tube-casts, or any other sign of renal disease; and yet I can hardly believe the albumen to be merely due to cystitis, for if that were so, it should be constantly present.

In one instance, I have followed for four years the history of a man who drinks to excess. At the beginning of, and for a time before, his attacks of delirium tremens, while he is consuming alcohol freely, he often has bloody urine, which will contain tube-casts of all the varieties at different times, fatty, hyaline, and granular. When he ceases his consumption of alcohol, as he has quite frequently done for two or three months at a time, the urine becomes normal, as far as chemical tests and microscopic examinations will reveal its condition. In the light of this case, how can we believe that the abuse of alcohol does not produce renal degenerations? Is not this man sure to die of Bright's disease, if he continues his indulgence in alcohol?

Another case was a man over fifty years of age, who was seized with rheumatism; he progressed badly, and was much more sick than the amount of rheumatism would seem to warrant, and at last, after about three weeks, died, having obstruction of the bowel and inflammation of the kidneys, as shown by the presence of albumen and tube-casts in the urine; also hydrothorax, and extreme stupor, which seemed uræmic. This man had had an attack of influenza about three or four weeks previous to his fatal illness. Can there be any connection between the severe influenza and the rheumatism, and renal inflammation and obstruction of the bowel, of which this patient died?

The last case I will mention was a boy, who died very suddenly, of congestion of the lungs, probably the first stage of pneumonia. A trace of albumen and granular casts were found in his urine, which was obtained a short time before death. This boy was about sixteen years of age, and did not seem much sick on the afternoon of one day, being up and dressed, the next morning dying, in a state of maniacal delirium, with his lungs extremely congested. There was, unfortunately, no post-mortem examination made. This case would seem one in which the pulmonary affection was primary, and yet it might be that he had a latent contracting kidney.

There has been much said of later years about kidney disease without the presence of tube-casts in the urine, and of the presence of casts without albumen. I may say that I have frequently found tube-casts in the urine when the most careful chemical examination failed to detect any albumen, and *vice versa*, have failed to find any casts at all, when the event proved the existence of renal disease.

The subject of treatment I have not even mentioned in my paper, although much might be said about it, because I have already trespassed too long upon your time.

In conclusion, I will briefly recapitulate the points which it has been my endeavor in this paper to prove.

First, that in no ordinary, uncomplicated case of Bright's disease, should a prognosis of speedy death, or even of incurable disease, be given, for I have related cases in which the disease was chronic, lasting more than two years, and which ended in complete recovery, and others in which the person affected has lived nearly nine years.

Second, that dyspnœa, usually taking the form of renal asthma, is much more common than is usually supposed, and when properly appreciated is a valuable diagnostic sign of the disease; also that severe coryza is a complication or accompaniment, and has a diagnostic value.

Third, that Bright's disease, as a cause of death, is on the increase.

Fourth, that it is a very common cause of the deaths of old people, probably being the direct cause in many deaths reported as of old age.

Fifth, that the passage of gravel, even when microscopic in size, but particularly if large enough to cause nephritic colic, is a prolific cause of the disease.

Sixth, that the occurrence of tube-casts in the urine without, or in advance of, the presence of albumen, is very common, and *vice versâ*, persons may die of Bright's disease, and the most careful examination fail to show any tube-casts, although there may be albumen constantly present in the urine.

Seventh, that the abuse of alcohol is certainly a cause of kidney disease, as proved by the case I have related, in which it has, again and again, caused hemorrhage from the kidney, with the temporary presence of albumen and tube-casts in the urine, disappearing again with the cessation of its consumption.

Pyrogallic Acid in Treatment of Venereal Ulcers.

Pyrogallic acid, recently introduced by Dr. Jarisch, of Vienna, has been used with success in the treatment of venereal ulcers, by M. Vidal, at the St. Louis Hospital, and M. Terillon, at Lourcine. The following unguent is employed at Lourcine:—

R.	Acid pyrogallic,	ʒx
	Amyli,	ʒx
	Vaseline,	ʒiv. M.

This unguent should be fresh and well guarded in a glass-stoppered bottle.

As fatty dressings to venereal ulcers are often inconvenient, M. Terillon recommends the following composition:—

R.	Acid pyrogallic,	ʒj
	Amyli,	ʒj. M.

This may be directly applied to the ulcers.

These applications, made daily, notably abridge the duration of treatment.

EDITORIAL DEPARTMENT.

PERISCOPE.

Nephrotomy and Nephrectomy for Pyelitis.

In the *Lancet*, Dr. George Elder records a case of scrofulous pyelitis occurring in a woman aged 36. Physical examination of lungs gave evidence of tuberculous disease. She first experienced severe pains down the left side and leg; painful micturition of turbid and scanty urine; no hæmaturia; to these were added, rigors, fevers, night sweats, occasional sickness, anorexia, progressive emaciation and loss of strength. The urine was strongly ammoniacal, muco-purulent, and containing triple phosphates in abundance. She did not pass more than sixteen ounces in twenty-four hours. She had a large, fluctuating, abdominal tumor, which was examined, under ether. Dullness extended from the anterior superior iliac spine up to and continuous with the cardiac area, and in a transverse direction from an inch to the left of the umbilicus round to the spinal column. The impression was given that the kidney was converted into one large abscess. Nephrotomy was performed by the usual lumbar incision, and a large quantity of curdy pus escaped. The kidney had been converted into two sacs. The shock was slight, and for a few days the urine was freer from pus than formerly; the wound discharged freely.

"An attack of septic pleuro-pneumonia of the right base, which all but ended the record of the case, coupled with the want of benefit following the nephrotomy, strengthened my resolve to extirpate the kidney as soon as the patient's condition warranted it. This I did, on June 20th, by enlarging the former incision and supplementing it by a crucial. There was very great difficulty in enucleating the kidney from its capsule, mostly experienced at the point of insertion of the vessels. The friability of its structure also contributed to this, and at the same time gave rise to copious bleeding, which pressure by means of sponges checked. I tied the blood vessels and ureter *en masse*, with strong carbolized Chinese silk, and then cut away the kidney. Under the strain of the ligature, the friable tissue of which the pedicle was composed gave way, and for a time the hemorrhage was appalling. A second and then a third were applied higher up, with the effect of stopping all bleeding, except from a few small arteries, which were separately ligated. A few loosely applied metallic sutures, simply used to approximate the edges of the wound, after it had been washed out with carbolized water and tamponed, finished a very tedious operation. Through failure of the spray producer it was not done antiseptically.

"The shock after the operation was extreme, so much so that for several hours it was doubtful whether the patient would rally. Frequently repeated rectal injections of pancreatized beef tea and brandy stood her in good stead. For the first forty-eight hours the scantiness of the renal secretion assisted in making the outlook more gloomy, but at the end of this time the quantity became natural in amount. After the operation its quality became normal, and has remained so ever since. With the above exceptions the patient made an uninterruptedly good recovery, and when she was discharged from hospital, on account of the annual cleaning, she had got quite plump, and there remained of the wound only a small sore.

"*Remarks.*—This was a very unpromising case upon which to perform such a grave operation, not only on account of the prostration induced by the condition for which relief was sought, but also because of the state of the chest and the drinking habits of the patient. I regret that the major operation was not at first performed, as by it time would have been saved and the inter-current attack of pleuro-pneumonia averted. The variations in temperature before alluded to ceased with the nephrectomy, as also the hemi-hyperidrosis, and before her discharge there was an improvement in the chest symptoms."

Fracture of Skull in an Infant—Death.

In the *Medical Times and Gazette*, Mr. Godlee reports the case of a child aged one year and seven months, who fell a distance of only two feet, striking the side of his face. He was stunned at first, but soon came round, and cried for about five minutes, after which he became drowsy; he retched several times, but was not actually sick. Some blood was flowing from left ear, which in a few minutes gave place to a watery fluid. On admission to hospital he was pale and drowsy; some tenderness behind left ear, pupils equal and reacted to light, no nervous symptoms of any kind. On the sixth day general convulsive movements of the limbs and face set in; in the afternoon the temperature ran up to 105°, and at 6 P.M. the child died.

At the *autopsy* an extensive fracture of the skull was found, beginning about the middle of the left parietal bone, in a bifid extremity, and extending downward to the back of the meatus externus; after passing a little forward, so as to reach the roof of the meatus, and separating the tip of the auditory process, it passed along the meatus, rupturing the upper and back part of the membrana; it then again bifurcated, the posterior part passing through the internal auditory meatus to the jugular foramen, the anterior extremity towards but not quite reaching, the foramen ovale. There was a considerable amount of pus in the cavity of the arachnoid, principally on the left side and at the base of the brain, but not extending to the upper parts of the hemispheres. Beneath the arachnoid, however, there was a copious effusion of puriform lymph, most abundant about the base of the brain, but extending in less amount to the sides and front of the hemispheres, and reaching to a smaller extent as far as the vertex. It extended along the medulla, and for two inches along the spinal cord; it also followed the velum interpositum into the third ventricle; but the

lateral ventricles did not contain an excess of fluid, and their contents were not abnormal. The vessels of the base were searched, both with the naked eye and the microscope, for tubercle, but no sign of it was found. The other organs, with the exception of the lungs, which were congested, showed no signs of deviation from health.

Remarks.—It is to be noted, in the first place, that severe fractures of the skull in children of this age are by no means common, their soft, elastic bones being indisposed to fissure in the same way as those of an adult. In the second place, it is remarkable that such an extensive fracture should result from so trivial an injury. The question of the possibility of a fall of two feet producing such a result as was found, suggested itself as one that might, under certain circumstances, have had a very interesting medico-legal bearing. But the most important lesson to be learned from this and similar cases is, that if a fracture of the skull ruptures the membrana tympani, and also passes across the internal auditory meatus, it constitutes not only a compound fracture of the skull, but a compound fracture of the skull communicating directly with the cavity of the arachnoid. No condition can be possibly conceived more favorable for originating a septic meningitis. It is surely wise to treat such a fracture on antiseptic principles, namely, to clear away all wax and discharge from the ear, and then to inject the meatus constantly with some one-to-twenty carbolic acid lotion, and to apply either a gauze or iodoform dressing, changing it when it becomes soaked. I can testify to the safety with which this may be done, and to the efficiency of the proceeding if it be done early, and not, as in this case, when the mischief has already occurred. It may be objected that even if the meatus externus be purified, the fracture still communicates with the external air through the Eustachian tube. This must be granted, but there is no more reason to suppose that organisms exist in the tympanum, than that they are to be found in the bladder, which we know is, under ordinary circumstances, not the case; the healthy mucous surface of the Eustachian tube, like that of the bladder, no doubt preventing the spread of these low forms of life along their surfaces. The blood which flows from the nose and mouth in many of these cases no doubt passes along the Eustachian tube, and if this takes place to any great extent it is perhaps likely that the fracture would be contaminated through this source; but, seeing how seldom prolonged bleeding takes place from these cavities, I would strongly urge that the line of treatment mentioned should always be adopted.

Operations for the Cure of Hernia.

In the course of a long article on this subject, in the *Annals of Anatomy and Surgery*, Dr. William Dunnet Spanton, of England, says:—

As a single matter of observation, and, in spite of the positive statements to be found in most writers to the contrary, it would appear that an infinitesimal proportion of cures are effected by the use of trusses. In the London Truss Society, out of a total of 96,886 cases of reducible hernia, only 4387, or 4.53 per cent., are said to have been cured in this way. A truss can only act by direct pressure on the part to which it is applied. But to close a hernial opening we need something more than this. As I have said, the moment the pressure is taken off the rupture descends afresh, and this must necessarily be so as long as the canal remains patent. If, therefore, it be possible to combine the filling up the canal itself with organized tissue at the same time that the tendinous boundaries are firmly approximated, we shall in this manner secure a much firmer support than in any other way.

The more recent procedures, having this object in view, consist of a variety of modes of ligature on the one hand, and my operation with the screw (or strephotome), on the other.

With regard to my own operation, I have now a record of over sixty cases, all of whom have recovered. The patients varied in age from five months to thirty-four years, and the herniæ differed in size, from small, tense ones to enormous, lax ones. All were of the inguinal kind, some oblique others direct, and a considerable proportion were congenital. An incision is made, large enough to admit the forefinger through the skin of the scrotum at the fundus of the hernial sac, an inch and a half or two inches below the pubic spine. The sac, with the fascial tissue covering it, is then separated from the skin, by passing the knife or the handle freely around the internal surface of the wound, until a sufficient extent has been separated to permit the finger easily to invaginate the sac into the hernial canal, which is readily accomplished by pushing the sac, with the left forefinger, up to the internal ring.

After carefully examining the condition of the parts within reach of his finger, especially with regard to the position of the blood vessels and the boundaries of the aperture, the operator retains his forefinger in the inguinal canal, thereby protecting the spermatic cord, which lies below his finger, and at the same time closing the internal ring so as to prevent any protrusion of the bowel. Sometimes, with a very patent ring, it is necessary for an assistant to place his finger externally on the groin to make perfectly sure of this, especially if there is any cough or struggling. It is, however, wiser to wait a few moments, and to let the patient become quiescent before proceeding further. Then, holding the strephotome firmly in the right hand, the surgeon thrusts the point through the skin of the groin at that part of the surface which corresponds to the outer pillar of the internal ring, which is also pierced by the point, which now comes in contact with the left forefinger. Having given the screw a turn, the point is made to pierce the invaginated sac, and pushed on through the internal pillar (conjointed tendon) as high up as can be safely reached, the left forefinger carefully guarding the

point of the instrument throughout. Another turn is now made, causing the screw to pass through the invaginated tissues and across the pillars of the external ring as many times as the length of the canal and the nature of the case will permit. The left finger is gradually withdrawn as the point passes downward and outward through the opening in the scrotum, the spermatic cord lying behind, and slightly compressed by the gradual tightening of the hernial canal. The point of the screw is then protected by a small india-rubber ball, and the handle lies flat on the outer surface of the abdomen. The scrotal wound is closed by a single wire or hair suture. In from seven to ten days the screw can be removed, and a compress used to keep the parts in position.

Digestion of Meat.

The *Lancet* says:—

It is well known that the digestion of different kinds of meat is the more easily effected the longer the time that transpires after the death of the animal. The explanation given is, that by keeping, the muscular fibres become gradually dissociated; they soften, become less compact, and consequently are more soluble in the gastric juice. According to physiologists, however, it is not considered advisable to wait until decomposition sets in, because, in addition to its losing a great part of its nutritive qualities, the meat becomes so nauseous that no amount of cooking, or the addition of condiments, will much improve it. MM. Pasteur and Lemaire, in an interesting paper lately submitted by them to the Academy of Sciences, stated that meat too far advanced, or what is termed "faisandée," is most unwholesome, and it is a mistake committed daily by sportsmen to wait until the game gets into this condition, for it is then simply unfit to be eaten. The above-named biologists have shown that tainted meat contains animalcules, which do the work of transformation and destruction; and as it is difficult to ascertain exactly the extent of putrefaction that the meat has undergone, one is liable to consume it just at the moment when it should be rejected. M. Pasteur and other micrographers are of the opinion that these animalcules, of which there are no less than thirty species, are of the same nature as those that are found in living animals suffering from virulent maladies, such as charbon, etc.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——Dr. Charles N. Hewitt's address, as President of the Minnesota State Medical Society, makes a pamphlet of 24 pp. It is in favor of a fixed standard of preliminary education, and a fair examining board.

——A study of the manner of transmission of syphilis in utero makes a pamphlet of a dozen pages, by Dr. Hugo Engel, of this city. His observations are acute and well worth reading. His favorite treatment is by mercurial inunction.

BOOK NOTICES.

Essentials of Vaccination. By W. A. Hardaway, M.D., etc. Chicago. Jansen. McClurg & Co. 1882. Cloth, 8vo, pp. 146. Price $1.00.

The beneficent discovery of vaccination is daily becoming more and more appreciated, in spite of the opposition to it manifested in certain quarters. The volume before us adds to the conclusiveness of the testimony as to its valuable prophylactic powers. Much of the author's space is taken up with the production and use of bovine virus, and on this account his essay will have especial value. In spite of all that has been written and spoken on the methods of propagating and employing this form of virus, an astonishing amount of ignorance about it prevails, and for that reason we hope Dr. Hardaway's book will be generally read. We have noted only one point where he seems to be at fault himself as to how vaccine matter should be used. That is (p. 110) where he says "the habit of using one quill for two persons is filthy and dangerous." It is singular that he did not appreciate that when one quill is used for two persons it is first *split in two* and each half used separately.

Rheumatism, Gout, and Some Allied Disorders. By Morris Longstreth, M.D. New York. William Wood & Co. (Wood's Library of Standard Medical Authors.)

Dr. Longstreth treats of the forms of rheumatism, its causes, pathology and ordinary course, its individual symptoms and peculiarities, complications, morbid anatomy, prognosis and treatment. The last three of the nineteen chapters of the work respectively, are on chronic articular rheumatism, gonorrheal rheumatism and gout. The author's opinions are carefully weighed, and his language even too cautiously non-committal in various passages. He writes from judicious observation, and his work merits careful reading.

The Diseases of Women, Their Pathology, Diagnosis and Treatment, including the Diagnosis of Pregnancy. By Graily Hewitt, M D. Fourth American edition. P. Blakiston, Son & Co. Price. paper, $1.50.

The work of Dr. Hewitt has been before the public more than ten years, and has been well received by the profession, both here and in England. The present cheap edition, with the author's latest revision, cannot fail to extend and confirm this popularity. It is neatly printed and contains 132 illustrations.

THE

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D. G. BRINTON, M.D.,
JOSEPH F. EDWARDS, M.D., } EDITORS.

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A PHILOSOPHER'S OBSERVATIONS.

As we have had a philosopher, and many think a great philosopher, among us, "takkin notes," this summer, to wit, MR. HERBERT SPENCER, it becomes us to collect with due diligence the pearls of wisdom which he lets drop from his lips.

Several of these have a medical bearing, and to them we give our attention. He made a speech in New York shortly before he sailed, in which he spoke of the characteristics of Americans. Among other things he said:—

"Everywhere I have been struck with the number of faces which told in strong lines of the burdens that had to be borne. I have been struck, too, with the large proportion of gray-haired men, and inquiries have brought out the fact that with you the hair commonly begins to turn some ten years earlier than with us. Moreover, in every circle I have met men who had themselves suffered from nervous collapses due to stress of business, or named friends who had either killed themselves by overwork, or had been permanently incapacitated, or had wasted long periods in endeavors to recover health. I do but echo the opinion of all the observant persons I have spoken to, that immense injury is being done by this high-pressure life—the physique is being undermined."

This was not a passing thought, but Mr. SPENCER went on to elaborate it with his customary fullness of illustration and force of expression.

There is no doubt a certain amount of truth in it. There is a great deal of high pressure in certain centres of American life; there is fast living in every sense in certain strata of society. But are we, as a nation, much given that way?

In spite of all those respected neurologists who have so much to say on this subject, and whose reiterated statements Mr. SPENCER did but echo, we do not believe it.

It is highly characteristic of a New York doctor to be ignorant that any part of the American nation lives outside of New York City; it is a venerable trait of travelers to judge all of a country by the few specimens or classes they see in a few weeks' or months' trip.

If Mr. SPENCER wished to see American life as it is carried on by the great mass of our fifty millions of people, he should have had us pilot him to an interior town of Pennsylvania, or some county seat in Virginia, or to some cross-roads general store in any one of thirty States, and have there passed a few weeks. If he had not found a life as dull, as monotonous, as free from nervous strain and high pressure, as any he had ever seen, then we are out in our reckoning. Yet it is just this life that forty-eight out of our fifty millions lead.

Of course, take the two or three greatest cities of any prosperous nation, and the two or three busiest streets, and the hardest brain-working classes in these cities, and they are under an unhealthy degree of pressure. But how absurd for a man, especially a philosopher, to be led astray by such a narrow and faulty generalization as to suppose what is true of these few is true of the mass! Yet that is just what Mr. SPENCER has done.

As to his supposed facts, that men grow gray sooner in the United States, that they suffer more from nervous collapse, that more kill themselves from overwork, there has never been, and is not now, any evidence that any of these are so. There is plenty of testimony to the opposite

statement, that our people are better fed, better clothed, have healthier lives, bodies as strong, and a surer prospect of a green old age, than the English, German or French in their own homes. Are we asked where is this testimony? We reply, where it has been to the interest of powerful and wealthy corporations to get it accurately, for business purposes, not for the sensation of an after dinner speech. We mean the Life Insurance Companies. Their tables show that the expectation of life is, in this country, on the grand average, rather better than in any of the three countries named, and in special fields very decidedly better.

So much for the value of all this talk about physical deterioration in the United States, and so much for the "broad and deep generalizations" which some philosophers indulge in about a vast nation and its constitution, after they have been dined and wined by a very select circle in one or two of its great cities, and have stayed over night at several of its finest hotels!

THE LATEST ABOUT BACTERIA.

This time it comes from America.

Dr. Formad, of Philadelphia has made some experiments, from which he is led to believe that, contrary to the generally accepted view, bacteria are not the cause *per se* of disease, but are merely the vehicle of contagion, the means by which the poison of certain diseases is carried from one organism to another. He has found the tubercle bacilli of Koch, or, at least, bodies identical with them, in the sputa of non-phthisical patients.

He has taken matter infested with the diphtheritic micrococci (first demonstrated by Professor Wood and himself), and has succeeded in producing the disease in animals, while micrococci from the very same specimen, *after a thorough washing in plain water*, were perfectly harmless.

He believes that bacteria exist in all nature, and that, even when charged with the elements of disease they cannot produce the disease unless they find a resting place in some body that is, on account of some unexplained conditions, a suitable pasture for the growth and development of the particular disease.

This view, which seems to be a very rational one, has two important practical bearings.

In the first place, it teaches us very forcibly the value of water as a disinfectant, and in the second place, it lends much additional force to the idea that infectious diseases are due to chemical influences, which theory, if demonstrated, will do much toward increasing the potency of our therapeutic resources.

If these bacteria carry certain elements that are capable of producing disease, it is not unreasonable to hope that chemistry will step in and tell us the chemical nature of these poisons; from this standpoint it will be but a step to name the chemical that will prove the antidote, and by this process can we arrive at the most rational treatment of infectious diseases. Dr. Formad promises to have more to say on this subject, and we look forward to his researches with interest, for it would seem that he is on the right track.

NUISANCES.

A correspondent writes us, from Ohio, as follows:—

"Please give us your opinion of the following case:—

"A business room in our town is occupied by a clothier; the room (cellar) below is occupied by a lot of *loud* Swiss cheese. The merchant says the odor is exceedingly offensive to him, and complains to the town council, and wants said body to pronounce, not the cheese, but the cheese stored in the room in such close proximity to his place of business, a nuisance, on the ground of the *unhealthfulness* of the odor and the dampness caused by the daily sweating of the cheese.

"Having been appealed to in regard to the above matter, I took the position that the air of the store-room being impregnated with the odor emanating from putrefactive changes brought about in the fats and caseine in the process of thorough ripening the cheese, is not a fit medium for constant consumption by the lungs of the storekeeper. Am I correct?"

Of course he is right. It is a fundamental and incontrovertible principle of sanitary science, that all or any organic decomposition must, and will, produce, as an accompaniment of this change, as a necessary condition of retrograde

metamorphosis, a condition of the atmosphere that is inimical to a perfect state of animal health.

It matters not whether the decaying organic material be a small cube of cheese or an elephant; the difference is only one of degree, and not of kind.

We need not discuss whether these enemies to health that are produced by organic decomposition are bacteria, or gaseous, or what not! For all practical purposes we know enough, and this knowledge tells us, in no doubtful terms, that all organic decompositions will produce poisons to animal life, and that they must all be declared public nuisances.

DIPHTHERIA.

From the Board of Health, we learn that diphtheria has, within the past two months, become quite prevalent in this city.

One of the most terrible of all diseases, it has succeeded so far in eluding the penetrating grasp of science, and we really know no more about it to-day, that is to say, about its causation and prevention, than we did two decades ago.

It was with the greatest pleasure and pride that we published, last spring, the report of Professor Wood and Dr. Formad, detailing their experience with an epidemic of diphtheria at Ludington, Mich.

They concluded that the disease was caused by a specific micrococcus, and the National Board of Health endorsed their conclusions.

But now, this very same Dr. Formad has demolished his own conclusions. Within six short months since his results were published, he has declared them untrue.

Still, this apparent contradiction of facts will, we doubt not, bear good fruit, for, from what we can learn, it seems certain that these bacilli and micrococci (about which we hear so much), have an important bearing on the production of disease, even though they do not produce the disease per se.

In the meantime, until we learn something more about diphtheria, we must carefully *isolate*, *disinfect* and treat to the best of our limited ability.

LOOK OUT FOR SMALLPOX.

The warning comes from the South; smallpox is prevalent in Chattanooga, Tenn.; so also is it, nearer home. A dispatch from Havre-de-Grace, Md., tells us that Harford county is much excited over the prevalence of smallpox, which was introduced into that community last summer by some men coming to work in a canning factory.

You must ever bear in mind that the causative agent of smallpox can be carried great distances and produce the disease. A man may come from a region in which the disease is prevailing, and while perfectly well himself, may carry in his clothing, his beard or his hair the seeds of smallpox, thus constituting a nucleus from which may originate a most devastating epidemic. The following fact must ever be borne in mind: *He who comes at all into contact with strangers is exposed to a greater or lesser degree of danger of infection.* The remedy, or rather the prevention, is to be found in thorough and universal vaccination and re-vaccination.

NOTES AND COMMENTS.

The Health of Criminal Women.

Dr. E. M. Mosher contributes an interesting article on this subject to the Boston *Medical and Surgical Journal*. His observations cover a period of four years, and were made upon 1704 cases of illness occurring among women committed to the Massachusetts State Reformatory Prison. He divides the women into three classes. Class I. Offences against person and property. Class II. Offences against chastity. Class III. Offences against public order. His conclusions are that

I. Intemperance and unchastity are the two vices which fill our penal institutions with women.

II. The influence of these vices is detrimental to health of body, increasing its susceptibility to disease, and lessening its recuperative power.

III. The diseases which follow as a direct result of these vices are syphilis, alcoholism, dyspepsia, rheumatism and general anæmia.

IV. Morbid conditions of body react upon the moral nature, increasing and perpetuating the tendency to criminality; hence the importance of careful medical supervision as a reformatory measure.

V. More ample provision should be made in all large cities for the isolation and thorough treatment of venereal patients of *both sexes*, either by the addition of special wards to the general hospitals or by the establishment of hospitals for this class.

VI. The women who commit high crimes, that is, larceny, burglary, arson, manslaughter, etc., possess a more sensitive nervous organization than those who commit only offences against chastity and public order.

Diagnosis of Fœtal Monstrosities.

That it would be exceedingly valuable, if the obstetricians were able to recognize before the delivery, if they have to do with an akencephalus, hydroencephalus, or other fœtal monstrosities, is clear. Prof. Calderini (*Ref. Deutsche Mediz. Zeit*, Aug. 10, 1882) has now demonstrated, from theoretical reasons as well—alteration of the pressure and increase of amnion fluid, in consequence of disturbed circulation and different functions of the kidney—as also on three successive cases of his own, that there always exists in cases of fœtal monstrosities hydramnios. This is plausible, and it would be well if further investigations should be made to settle the question, as many a delivery would be made in a different manner, if the obstetrician knew beforehand that he had to deal with a monstrosity.

Subcutaneous Injection of the Salts of Pilocarpin.

The salts used are the nitrate and the chlorhydrate, and the principal physiological effects are; congestion of the skin, principally of the face, exaggeration of the natural secretions, particularly of the salivary and sweat glands; acceleration of the action of the heart; elevation of the temperature at the initial period, which becomes persistent if diaphoresis does not take place later on; there is a more or less marked fall in temperature according to the abundance of transpiration.

Given in ordinary physiological doses, the salts of pilocarpin never induce vomiting or diarrhœa, or the sensation of extreme feebleness often noted after the administration of infusion of Jaborandi. Accidents produced by administration of the salts of pilocarpin at a less dose than one-third of a grain rarely occur, except in patients having some form of cardiac disease.

The injections hardly ever give rise to local accidents; it is well to commence with feeble doses, about $\frac{1}{12}$ of a grain, and gradually increase from that to $\frac{1}{8}$, $\frac{1}{4}$ or even one grain. When the daily dose administered is half a grain or more, it will be well to inject one-half in the morning and the other in the evening. Pilocarpin is employed in therapeutics, where it is thought possible to obtain a very marked curative effect from abundant sudation or from a greatly increased secretion of saliva. Hypodermic injections of pilocarpin have accordingly been principally employed in the treatment of the different forms of dropsy, in pleurisy, bronchitis and pneumonia, and in the treatment of acute articular rheumatism, epilepsy, eclampsia, etc.

Heredity of Sebaceous Cysts.

In the course of a clinical lecture, reported in the *College and Clinical Record*, Prof. S. W. Gross says:—

This man, who has a prominent swelling upon his scalp, tells me that his mother had a similar development. I asked him the question incidentally, because I had in mind the case of a man suffering with mammary cancer, upon whom I operated at this clinic, whose scalp was covered with these excrescences, and his daughter who came with him also had a number of them. Let me say in this connection that many surgeons mention as one of the points of difference between a malignant and a benign growth, that only the former is inherited. They seem to overlook that this also occurs in innocent tumors, even with the simplest of all, the sebaceous cyst.

Removal of Warts.

Dr. Unna, of Hamburg (*Monatschrift Prakt. Dermat.*, 3, '82), had a young girl under his charge, whose dorsal surfaces of both hands were the seat of over a hundred warts, daily more making their appearance. He made on gauze tissue a plaster mass, which contained 10.0 grm. arsenic and 5.0 grm. of mercury. This was kept on during day and night. Two weeks later all warts had disappeared and the healthy skin was seen. The cure here is not established by necrosis and dropping off of the excrescences, but like nature's spontaneous cure, by resorption.

We ourselves used to make cauterization our main treatment for the removal of condylomata.

A year ago, a patient came to us, who, besides suffering from icterus, due to catarrhal inflammation of the bile ducts, was affected with condylomata also. As the latter were very large, preventing the prepuce from being drawn forward, their removal was desirable. They gave rise to an annoying itching and to a fetid odor. Not wishing to operate on them while the patient still had the jaundice, we told him to dust the parts daily with

℞. Hydrarg. muriat. mit., ʒj
Acid. borac. pulver., gr. x. M.
Fiat pulvis.

and were not a little astonished to find three weeks later not a sign of them left. They were all absorbed. Since then we have often had occasion to use this powder, and invariably with the same good success.

Angina Pectoris—Death.

Dr. J. M. Stevenson reports a somewhat interesting case of angina pectoris, in the Pittsburgh *Med. Jour.* A man, aged 64, temperate and active, after being engaged in active work all morning, ate a full dinner. Immediately afterwards, with a cry of pain, he sank to the floor, struggling and insensible. Brandy and strong aromatic spirits of ammonia failed to elicit any evidence of their irritant properties. After using a variety of remedies, six drops of nitrite of amyl were poured upon a handkerchief and administered very cautiously, allowing an abundance of air. After a few inhalations the face became flushed, pulse increased in frequency and fullness, respiration became quicker, in ten minutes all struggling ceased, and in twenty minutes consciousness returned. Three days subsequently he had a similar attack, which was relieved by the same means, but on the evening of this day he had another, and no one being present to administer the amyl, he died in five minutes. A post-mortem was refused.

Sulphurous Acid in Consumption.

Most readers are aware that sulphurous acid is one of our most important bacillicides, and the more to be recommended, as it can be inhaled with impunity. Mr. Julius Kircher, a pupil of Liebig, and owner of a chemical factory in Brooklyn, writes as follows to the *Zeitsch. f. d. œstr. Apoth. Verein.*

The observation of Koch has found a brilliant confirmation in my factory, where a large quantity of sulphur is evaporated daily. That in this process a great deal of sulphurous acid is formed can easily be imagined. During the forty-four years that my factory has existed none of the many laborers have ever been affected by tubercular consumption, nay, more, frequently enough persons in the beginning stages of this disease applied for admittance and were cured within a few weeks, simply by inhaling the sulphurous acid. If not too far progressed, these individuals become strong, stout, and perfectly healthy again.

All diseases zymotic in character, even cholera, stay away from his factory and those working there. Persons affected with bronchial catarrh are rapidly cured.

Phthisical patients should live in rooms where hourly 1 to 2 drachms of sulphur are evaporated on a warm stove. First eight or ten days there is increased irritation of cough and expectoration; then these cease, and the individual rapidly improves. Convalescents should live for a time in rooms filled with aromatic watery vapors.

Nephrotomy.

In the course of the Presidential address at the last annual meeting of the Yorkshire Branch of the *British Medical Association* (*British Medical Journal*), Dr. T. R. Jessop reported the following interesting case: The patient was a female. Purulent urine was being painfully squirted every few minutes from an intolerant bladder. Nothing more than the single fact of purulent urine could be developed by the most careful physical, microscopical, and chemical examination. The neck of the bladder was dilated, and when the forefinger was swept around the interior of the viscus, the left ureter could be felt in the wall of the bladder, as firm and as prominent as a whip-cord, while the orifice of the right could only with difficulty be made out. The left kidney was exposed in the loin, its substance was incised, and from its pelvis there exuded from two to three ounces of offensive pus, after which an uninterrupted recovery took place.

Acute Heart Lesions in the Very Old.

It is a well-known fact, that acute diseases of the heart, at least, undoubtedly those of an inflammatory character, happen very rarely in the aged. Dr. Ch. Féré (*Revue de Med.*, 1882, *No.* 3) draws attention to a new etiological cause for these lesions. Among 134 autopsies which Féré made during seven months in the Salpêtrière he found seven acute diseases of the heart, peri- and endo-carditis. Of these, in one case the acute pericarditis had appeared as a complication of pleuro-pneumonia (in senile persons

a very rare occurrence), and six had happened in consequence of diffused kidney lesions. Two of the latter were the common senile lesions of the kidneys; in the four other cases, however, secondary disease of these organs, besides dilatation of the pelvis of the kidneys and of the ureters, due to obstruction in the urinary passages, were noted. Féré mentions correctly, that these complaints are not common enough to be considered an accidental coincidence with the keart affection.

Local Treatment of Erysipelas.

Dr. Rothe recommends (*Memorabilien*) the application of the following liquid every two hours to the affected parts.

℞. Acid carbolic,			
Alcohol,	āā	1 part	
Ol. terebinthinæ,		2 "	
Tr. iodinii,		1 "	
Glycerinæ,		5 "	M.

This mixture causes no pain. Internally, he recommends quinine and digitalis, and an emetic if indicated.

The Cause of Tetanus.

Dr. F. Schuttze reports, in the *Neurol. Centrlbl.*, 1882, No. 6, the microscopical examination of the central nervous system of four cases of traumatic tetanus. In all the cases, nothing was found which would have been characteristic for an acute meningitis or myelitis. Schuttze is with justice opposed to all vague publications of the post-mortem examinations of such cases, and mentions that whatever he had read, so far, of such reports, were simply normal post-mortem appearances, which could be noted in any dead body. The anatomical cause of this dreadful disease continues, therefore, still to be unknown.

A New Anti-Scorbutic.

The *Med. Times and Gaz.* says that "amchur," which is made from green mangoes that have been skinned, stoned, cut into pieces and dried in the sun, has been introduced among the native soldiers in India as an excellent substitute for lime juice in scurvy. It also promotes digestion. One ration should be half an ounce, which would be an equivalent for one ounce of good lime juice.

Vaccinal Micrococci.

The *Lancet* says that M. Straus has plainly demonstrated the presence of the special micrococcus in microscopical preparations of the vaccinal pustule from the calf. He places the excised fragments of skin in absolute alcohol, cuts sections and stains them with methylamine violet, and then discolors them, until only the nuclei, the bacteria and micrococci remain visible. Under a strong magnifying power, the latter were visible, as extremely minute points, tinted blue, about a thousandth part of a millimetre in diameter, and grouped in colonies.

Correspondence.

A Numerous Progeny.

Ed. Med. and Surg. Reporter:—

There is a farmer living in this county, about eighteen miles from this city, who has nine children, the oldest of which is ten and the youngest two years old. I will give their ages, sex, etc.:—

Girl	10 years.
Twins (boy and girl)	8 "
" " "	6 "
Girl	4 "
Triplets (all girls)	2 "

These children are all living and healthy, and the parents are also healthy. Who can beat this?

Maryville, Mo. J. B. Morrison, M.D.

News and Miscellany.

Medicine in England in the Beginning of this Century.

In the course of the Introductory Address delivered at University College, London, Mr. Marcus Beck, in describing the past history of medicine in England, said "At the beginning of this century the profession was divided into distinct grades.

There were, first, the physicians who had, as a rule, received such scientific education as was to be obtained at that time. They had mostly attended lectures at one of the English or Scotch Universities, and spent some time in practical study in a hospital. Then there were the surgeons, licensed by the College of Surgeons, then just founded in its present form. These also had received some education in anatomy and surgery.

Lastly, there were the apothecaries, and to them fell the larger share of medical practice of the time. It was not uncommon, however, for these two last to be joined together in the person of one man, forming the surgeon-apothecary, who was the precursor of the modern general practitioner. The practice of the apothecaries differed from anything we have within the limits of the legitimate medical profession in the present day. They were essentially prescribing druggists, and could legally charge only for the medicine they prescribed. Thus they could receive no remuneration unless they ordered some medicine, and the more they ordered the more they got; a style of practice calculated to inspire a firm belief in the efficacy of drugs. It was not

necessary for the apothecary to receive any medical education beyond being apprenticed to some one already in the trade, and the jurisdiction of the Society of Apothecaries, which necessitated even this amount of training, only extended to a distance of seven miles around London.

The Epidemic of Typhoid Fever in Paris.

The latest information shows that the epidemic has assumed terrifying proportions. On October 22d there were 2175 typhoid fever cases in the hospitals. For the week before, from 25 to 50 patients were daily admitted to the hospitals suffering from this disease. On October 24th twenty-five burials of persons who had succumbed to the disease at their own residences, took place; on the 25th eleven. After October 15th the daily number of admissions to the hospitals ranged from 25 to 77, while from the 9th to the 14th they oscillated between 86 and 180.

At the commencement of the epidemic, the hospital administration was petitioned to create new services, but the work went on with characteristic slowness, although there is a new hospital (l' Hop. Bichat), all ready to receive beds, etc. Finally, when all the chronic cases had been discharged and the already filled wards encumbered with cot-beds, they set about hastily constructing barrack hospitals in the grounds of the Hôp. Cochin, Midi, etc. Even with these new services the hospitals are encumbered and the administration has been again obliged to open the provisory services in the two ancient edifices formerly belonging to the old Hotel Dieu, on the left bank of the Seine.

The hospitals of Paris, notwithstanding their number, prove totally inadequate when any epidemic occurs, and at the best of times are often encumbered with cot-beds.

The Secret of Noble Life.

Mr. Jonathan Hutchinson thus concluded his Introductory Address at the London Hospital: "If now I were to sum up in one sentence what I have been enforcing, it would be this; the secret of all noble life lies in belief, and the characteristic of all noble minds is the vigor with which they believe that which is true. Try to attain belief in the reality of all things; so shall you never want for motives, so shall you be able to live and work without hurry and without sloth. Finally, permit me to commend to you this formula; prize strength, love the beautiful, practice self-denial, and be patient."

Statistics of Suicide in Prussia.

According to details from official sources, which have recently been published in the German press, suicide is on the increase in Prussia, the annual proportion of self-inflicted deaths per 100,000 of population having risen from 13 in 1869, to 18 in 1880. The manner in which these suicides are carried out does not seem to have varied much, with the exception of a greater preponderance of poisoning among the female cases. May, June and July are the months most fatal in this respect. The number of suicides in each period of human life seems to increase with more or less regularity until the stage between fifty and sixty years of age is reached, which shows the highest proportion. There is an excess of deaths shown for the period between twenty and twenty-five years of age; still it does not alter the general fact as to the later portion of middle-age showing the most cases of suicide.

The Health of Providence, R. I.

According to the report of the health authorities there were 47 deaths in Providence for the week ending Nov. 11th, a slight increase on recent weekly averages. The youngest decedent was 4 days, and the oldest 86 years. Typhoid fever caused 10 deaths, which accounted for the total increase. There are about 214 cases of typhoid in the city. The severity of the disease may be judged from the reports of the physicians, which are as follows:—

Disease mild, 49 cases, or 23 per cent. of all. Disease average, 103 cases, or 48 per cent. of all. Disease severe, 62 cases, or 29 per cent. of all. Disease malignant, no cases. Total, 214 cases.

In the first week less than six per cent. of the cases were reported as "mild," in the last week more than 28 per cent. were so reported. The outbreak is very sudden and very severe, but probably very transient, and what is somewhat peculiar, is spread throughout the city and not confined to any one locality.

Certificates in Sanitary Science

The College of Physicians in Ireland has recently made arrangements for granting certificates in Sanitary Science. Stated examinations will be held in January, April, July, and October. Every candidate must be a Licentiate in Medicine, of the College, and must lodge a fee of five guineas, which will not be returned in case of rejection. The examination will comprise the following subjects: 1. Engineering, including hospital and house construction, sewage, drainage, ventilation, and water-supply. 2. Law; the Acts relating to Public Health; duties of health officers. 3. Etiology and prevention of disease; epidemiology, contagion, infection, hereditary influence, accommodation and conveyance of the sick, and the management of hospitals. 4. Chemistry; air, water and food. 5. Meteorology and climatology; vital statistics. The candidate will also be examined in the analytical chemistry of air, water and food.

Vinegar for the Sick Room.

The Boston *Journal of Chemistry* says:—There is a French legend that, during the plague at Marseilles, a band of robbers plundered the dying and the dead without injury to themselves. They were imprisoned, tried and condemned to die, but were pardoned on condition of disclosing the secret whereby they could ransack houses infected with the terrible scourge. They gave the following recipe, which makes a delicious

and refreshing wash for the sick-room: Take of rosemary, wormwood, lavender, rue, sage and mint, a large handful of each. Place in a stone jar and turn over it one gallon of strong cider vinegar; cover closely and keep near the fire for four days, then strain and add one ounce of powdered camphor gum. Bottle and keep tightly corked. It is very aromatic, cooling and refreshing in the sick-room, and is of great value to nurses.

Philadelphia County Medical Society Lectures.

A course of lectures by Prof. Austin Flint, Senior, of New York, on "The Physical Exploration of the Lungs by means of Auscultation and Percussion," will be given in the hall of the Society, N. E. Cor. Thirteenth and Locust streets, on Saturday, November 25th, December 16th and January 13th, at 8 P. M.

Lecture I.—The True Mode of Study and its Requirements as Regards Auscultation and Percussion. The Signs Obtained by Percussion.

Lecture II.—Auscultation and the Respiratory Murmur, with its Abnormal Modifications.

Lecture III.—The Râles and the Vocal Signs.

Com. on Lectures { John B. Roberts, *Ch'n.*; Chas. H. Thomas; Wm. S. Little; M. S. French; Edward T. Bruen.

The Athletic Association of the University of Pennsylvania.

The old University, ever foremost in all true progress, has determined to make a new departure. We have received a circular from a committee, who have in hand the organization of an Athletic Association, which shall comprise five departments: Boating, Foot-ball, Base-ball, Cricket and Athletics. There is no entrance fee, and the annual dues will be three dollars. It is proposed to lay out a running track, cricket, tennis, base-ball and foot-ball grounds, and build a gymnasium on the University grounds. To all who realize the importance of a *sound body* as the habitat of a *sound mind*, this proposed improvement will heartily commend itself. Any one desiring further particulars can address any of the committee, consisting of J. William White, M.D., H. Laussat Geyelin, Thos. G. Hunter.

The Veterinary College of the University of Pennsylvania.

A subscription of $10,000 has been received by the University of Pennsylvania, for the establishment of a veterinary college. Several physicians of reputation and ability are now in Europe, pursuing special courses of study to qualify them to fill professorial chairs in this new college.

Lebanon County Medical Society.

Dr. Carl Seiler, of this city, will deliver a lecture before the Lebanon County Medical Society, on the first Tuesday in December. His subject will be "Nasal Catarrh; Its Pathology and Treatment." The lecture will be illustrated by drawings, and patients will be operated upon.

Two Cases of Poisoning from Whisky.

The Glasgow correspondent of the *Lancet*, writes as follows: Two cases of poisoning from whisky drinking have been noted in our daily papers during the past week. One man had been drinking in a public-house till a late hour, and on going home he procured a further supply of liquor; shortly afterwards he fell asleep, and in a few hours fell from his chair, dead. The other case was that of a man who, in drunken bravado, agreed to drink a whole bottle of whisky "without taking it from his head," and did so, with the result that he soon became comatose, and had to be removed to the Infirmary.

Proposed Sanitary Museum in Sunderland.

A praiseworthy attempt is about to be made in Sunderland to extend the knowledge of sanitary matters among the residents in the North of England. The effort is initiated by Dr. Mordey Douglas, senior physician to the Sunderland Hospital for Sick Children, who proposes that the new municipal buildings be made to include accommodation for a permanent exhibition or Sanitary Museum, in connection with which lectures on health subjects may be delivered from time to time, the discourses to be illustrated by the various exhibits. The proposal is a good one and worthy of successful realization.

Public Nuisances.

At a recent meeting of the Board of Health of this city, nuisances were reported as existing at several points. A row of unfinished buildings were said to be unsafe, and water in the cellars emits a disagreeable smell. The Medical Inspector will make an examination.

We frequently see such reports and statements in the daily papers. We must say most emphatically that the public health imperatively demands that such nuisances should not be tolerated an hour.

The Commencement of Scientific Medical Education in England.

According to the Introductory Address of Mr. Marcus Beck, at University College, London, that institution, then called London University, was founded in 1826, and for the first time a systematic scientific education was given in London, on essentially the same lines as are followed to the present day.

Carlyle's Patience.

In his Introductory Address at the London Hospital, Mr. Jonathan Hutchinson, speaking of Carlyle, said: "He had not learned what we may, I think, without irreverence, style the Religion of Patience. By patience I mean not the mere passive virtue of endurance, which, indeed, is not unfrequently no virtue; I mean rather the ability, when we have done our best, under all possible circumstances, to rest undespairingly and trustfully for the result."

Poisoned by Mistake.

Up in Ontario, a short time ago, a man and his two daughters took some "herb tea," to relieve colds. They were all taken violently sick and died. It is supposed that deadly nightshade was among the herbs. We desire to say, in most emphatic terms, that he who attempts to meddle with drugs about which he knows nothing, is playing with fire, and can only be characterized as a very foolish person.

Unwitting Suicides.

This time it comes from New York. A man and wife *blow* out the gas in a room in a hotel, and the next morning are found dead. Thorough ventilation of rooms, active and intelligent night watchmen, and a general watchfulness over the guests of a hotel, might do much toward preventing these catastrophes, which are becoming altogether too frequent.

The Health of the Jeannette Arctic Exploring Expedition.

Lieutenant John W. Danenhower says that during all the time the Jeannette was imprisoned in the ice, the health of the crew was excellent. They were away from civilization of all kinds, floating about or imprisoned in the ice, for twenty-eight months, and not a single case of scurvy occurred. The expedition was a temperance one.

Unobstructed Drainage.

The City Solicitor of Philadelphia has rendered an opinion, in which he holds that the city is obliged to dredge docks into which the city sewers empty. This is a very important decision, since a free and untrammeled outlet for all sewerage is one of the prime essentials of a healthy city. Such action should be made compulsory upon the authorities of all cities draining into rivers.

Degrees of the University of Pennsylvania Open to Women.

At a special meeting of the Board of Trustees of the University of Pennsylvania held November 14, it was resolved that any of the degrees or honors of the University could be conferred upon women who shall pass the proper examinations.

Items.

—Hildebrandt, the eminent teacher of gynæcology, in Koningeberg, is dead.

—Duncan Campbell, M.D., a member of the Local Government Board, of Nova Scotia, died Nov. 15th in Port Hood.

—Dr. J. S. Mohr was found dead in his office in Chicago, Nov. 15th. He had apparently been dead for several days, but there were no marks of violence upon his person.

—On Nov. 15th, the Board of Health issued a proclamation declaring the epidemic of yellow fever in Pensacola at an end, but advising absentees to keep away a little while longer.

—An ordinance relating to the prevention of the spread of infectious diseases, was favorably reported by the Law Committee of Councils of this city, on November 15th.

—The Camden County Medical Society, on Tuesday, Nov. 14th, appointed the following committees: On Medicine, Doctors Snowdon, Mulford, Smith; Surgery, Benjamin, Gross and Blake; Obstetrics, Mecray, W. A. Davis, Jennings; Microscopy and Pathology, Ridge, Henry, Shivers, Hamilton; Medical Jurisprudence, Garrison, Ireland, Iszard; Nervous Diseases, Armstrong, Stout and Young.

—The officers of the American Public Health Association for the ensuing year are: President, Dr. Ezra M. Hunt, New Jersey; First Vice-president, Dr. Albert L. Gihon, U. S. N.; Second Vice-president, Dr. J. E. Reeves, Wheeling, W. Va.; Treasurer, Dr. J. B. Linsley, Nashville, Tenn.; Executive Committee, Dr. Thomas L. Neal, of Onio; T. J. Turner, of the U. S. Navy; G. P. Conn, of New Hampshire; J. F. Billings, of the U. S. Army; J. J. Speed, of Louisville, and H. D. Frazer, of South Carolina.

OBITUARY NOTICE.

DR. SAMUEL WHITE THAYER,

A distinguished physician and one of the most eminent citizens of Vermont, died in Burlington, Nov. 14th, after a long illness, of blood poisoning, aged sixty-five. During the war he was surgeon-general of the staff of the Governor of Vermont, and established and organized three military hospitals. He leaves a widow and one son, Dr. Charles P. Thayer, of Boston.

QUERIES AND REPLIES.

A. O. S., Pa.—"Infarction" means a stuffing or blocking up.

V. W. J.—We would suggest measures looking to the relief of the dyspepsia, to overcome the constipation; producing daily free evacuations, as well as friction and support to the abdominal walls, until they regain their tonicity.

MARRIAGES.

COLLINS—LA TOURRETTE.—At Fort Union, on Thursday Oct. 5th, 1882, by the Rev. Jas. A. M. La Tourrette, Post Chaplain U. S. A., assisted by the Right Rev. Bishop Dunlop, of New Mexico, Genevieve, daughter of the officiating Presbyter, and Dr. Joseph H. Collins, A. A. Surgeon, U. S. A.

GRIFFITH—JENKS.—In the Woodlands Presbyterian church, Philadelphia, October 5th, by Rev. Dr. Benjamin Griffith, assisted by Rev. Dr. Crowell, Dr. J. F. Crozer Griffith, and Julia E., youngest daughter of Barton H. Jenks, all of Philadelphia.

DEATHS.

BENNETT.—Suddenly, at his residence, in Danbury, Conn., Oct. 27th, Ezra P. Bennett, M.D., aged 76.

BOND.—In this city, Oct. 26th James Bond, M.D., in the eighty-third year of his age.

COMLY.—In this city, Oct. 28th, Dr. Isaac Comly, in the 73d year of his age.

HOWELL.—In Woodbury, N. J., October 10th, Benjamin Howell, M.D., in the seventy fourth year of his age.